COLORADO
Department of Health Care Policy & Financing

303 E. 17th Ave. Suite 1100
Denver, CO 80203

Hospital Discounted Care Operations Manual

Fiscal Year 2025-26

Section II: Eligibility and Screening

Article I. PATIENT ELIGIBILITY REQUIREMENTS

Section 1.01 General Eligibility Requirements

Patients and their households are eligible for Hospital Discounted Care if, during the required screening and application processes, they are determined to:

- Have a total household income at or below 250% of the Federal Poverty Guidelines (FPG), and
- Be residents of the State of Colorado.

Health Care Facilities may establish policies that:

- Extend Hospital Discounted Care eligibility to non-Colorado residents, either generally or on a case-by-case basis; and/or
- Approve eligibility for the facility's own internal charity care program for households with incomes above 250% of the FPG, if the facility has a program that covers higher income households.

Section 1.02 Federal Poverty Guideline (FPG)

The FPGs are income thresholds issued each year by the U.S. Department of Health and Human Services (HHS). These guidelines are used to determine eligibility for federal and state benefit programs, including the Hospital Discounted Care law.

Hospital Discounted Care regulations apply to patients with household incomes up to 250% of the FPG.

The Colorado Department of Health Care Policy & Financing (HCPF) updates the Uniform Application at least twice each year:

- April 1: to align FPG values with Medicaid updates.
- July 1: to align with the start of the state fiscal year.

For Hospital Discounted Care, a patient's FPG percentage is calculated based on their gross household income and household size, as defined in the sections that follow. Hospitals may use the FPG Calculator available on the HCPF Hospital Discounted Care Rates website under *Hospital Discounted Care Maximum Payment Calculator*.

Section 1.03 Household Definition

For Hospital Discounted Care, *household size* is based on all individuals who share financial or residential ties with the patient. The patient must include their spouse in their application, as spouses are responsible for each other's medical bills per Colorado law. Anyone who meets the criteria below may be included on the patient's application.

Individuals Who May Be Included

A person may be counted as part of the household if they meet any of the following:

- They live at the patient's address;
- They live outside Colorado or the United States but receive 50% or more of their financial support from the patient or the patient's guardian;
- They are an unborn child of any pregnant household member;
- They are a child age 18 or older who is still in high school or college and supported by their parents; or
- They are a child with a disability, of any age, who is financially supported by the patient or the patient's guardian.

Non-spouse or non-civil-union adults under age 65 may only be included if the patient or guardian attests to providing financial support.

Adults

Unmarried adults who live together may submit one joint application only if both agree to be included. Otherwise, each person must complete their own application. This includes adult children living with parents or guardians, adult siblings, unrelated roommates, and couples who are not legally married and do not meet the definition of civil union or common-law marriage.

Married Couples

Under Colorado law, a spouse or civil union partner must be included on the application when a legal marriage or civil union exists. This also applies to common-law marriages, which require all of the following:

1. Both parties intend to be spouses;
2. Both are 18 years of age or older;
3. Both are free to marry (single, widowed, or legally divorced);
4. Both live together; and
5. Both present themselves publicly as married.

Spouses or partners are not required to share the same last name. Married or civil union couples who wish to apply separately must be legally separated or in the process of legal separation or divorce. Documentation is required and may include court filings or a letter from an attorney or other assisting party.

Minors

A minor should not have a separate determination unless emancipated or there is a special circumstance, such as:

- The minor is a parent seeking medical care for their child;
- The minor receives examination or treatment for sexually transmitted diseases, including HIV;
- The minor seeks treatment for alcohol or drug addiction;
- The minor receives obstetrical or gynecological care, including birth control;
- The minor seeks voluntary mental health services and is 15 years of age or older; or
- The minor participates in the Confidential Teen Services Program.

If a pregnant minor's parents have insurance that excludes pregnancy but still claim financial responsibility for the minor, the parents' income must be used to determine eligibility. For minors in the Confidential Teen Services Program, eligibility is based only on the minor's personal income. If the minor has no income, they should not be billed for services.

Religious Orders

Members of religious orders who are not related must each complete separate applications. Health Care Facilities should not include unrelated members of religious orders on the same application.

Section 1.04 Household Income

All income for each person included in the household must be counted when determining total household income for Hospital Discounted Care eligibility.

Exceptions:

- Income from working minors or adult students who live with their parents or guardians is not included.
- If an adult student applies independently (not as part of a parent's or guardian's application), their employment or self-employment income must be included.

Definition of Household Income

Household income includes both earned and unearned income as described below. Income sources not listed below should not be included in the Hospital Discounted Care income calculation.

Earned Income:

- Wages or salaries from employment for all working, non-student adults aged 18 and older.
- Self-employment income for all working, non-student adults aged 18 and older.

Unearned Income:

Unearned income for all household members must include:

- Social Security Income
- Social Security Disability Insurance (SSDI)
- Tips, bonuses, and commissions
- Short-term disability payments
- Pension payments
- Payments from retirement accounts
- Lottery or gambling winnings (as disbursements)
- Regular payments from trust funds
- Unemployment benefits

Exceptions for Social Security and SSDI

Social Security and SSDI payments must not be counted as income for minors or for adults with disabilities who remain under the care of their parents or guardians. However, Social Security and SSDI must be included as income when an adult with disabilities applies independently.

Section 1.05 Health First Colorado and CHP+ Members

Patients who are currently enrolled in Health First Colorado (Colorado's Medicaid Program) or Child Health Plan *Plus* (CHP+) and who have full coverage benefits are not eligible for Hospital Discounted Care.

Patients who receive limited benefit coverage - such as Emergency Medicaid, Family Planning Services, or the Breast and Cervical Cancer Program (BCCP) - may be eligible for Hospital Discounted Care for services not covered by their limited benefit plan.

Patients who later gain full Health First Colorado or CHP+ benefits may apply for Hospital Discounted Care to cover services received before their coverage began. However, Hospital Discounted Care cannot be used to pay for services denied by Health First Colorado or CHP+.

Section 1.06 Patients in the Custody of Law Enforcement

Eligibility for Hospital Discounted Care depends on whether the patient is currently in law enforcement custody or free to leave at the time services are provided.

Patients Not in Custody

Patients who are brought to the facility by law enforcement but are free to leave once treatment is complete are not considered to be in custody. If these patients are uninsured, they must be screened for Hospital Discounted Care.

Patients on Parole or Probation

Patients who are on parole or probation after incarceration are eligible to be screened for Hospital Discounted Care. This includes individuals residing in halfway houses throughout Colorado, except those living at Gateway: Through the Rockies. Patients on parole must provide documentation verifying their parole status.

Patients Currently in Custody

Patients who are in the custody of a law enforcement agency are not eligible for Hospital Discounted Care, except in the following cases:

- The patient is being treated for a self-inflicted injury, or
- The patient is being treated for a pre-existing medical condition that began before being placed in custody.

This rule applies to patients who are:

- Detained and not free to leave;
- Serving sentences for criminal offenses;
- Involuntarily confined in city, county, state, or federal correctional or detention facilities;
- Awaiting trial in detention centers; or
- Involuntarily residing at wilderness camps or other facilities under governmental control.

County Responsibility for Medical Costs

Under C.R.S. § 17-26-104.5, the county is responsible for paying the cost of medical services for inmates, unless the patient’s doctor determines that care was provided for:

- A self-inflicted injury, or
- A pre-existing condition.

In those cases, the patient may be eligible for Hospital Discounted Care.

Screening Procedures

Health Care Facilities should make all reasonable efforts to screen eligible patients before discharge. If screening cannot be completed while the patient is at the facility, the hospital should contact the law enforcement agency that has custody of the patient to complete the screening if the patient was seen for a pre-existing condition or a self-inflicted injury.

Article II. SCREENING PROCESS

Section 2.01 Uninsured vs Insured Patients

Health Care Facilities are required to:

- Screen all uninsured patients, and
- Screen any insured patient who requests financial assistance.

See Section III: Application and Determination Notification, Section 2.04 Notification of Licensed Health Care Professionals for information on Health Care Facility responsibilities related to communicating patient screening and application status to professionals.

Determining Insurance Status

A. Patients Without Creditable Coverage (Uninsured)

A patient is considered **uninsured** if they do not have Creditable Coverage. Creditable Coverage includes the following health benefit programs:

- Medicare
- Health First Colorado (Colorado's Medicaid Program)
- Child Health Plan Plus (CHP+)
- Private health insurance (through employment, the marketplace, or a state health benefits risk pool)
- Tricare
- Indian Health Services (IHS)
- Federal Employees Health Benefits (FEHB) Program

- Public health plans
- Peace Corps health care programs

All other patients are uninsured and must be screened for Hospital Discounted Care. Any patient who has a limited benefit plan through any of the above that does not cover the type of service they receive is also considered uninsured and must be screened. For example, a patient who receives outpatient care but only has Medicare Part A (inpatient care) should be screened for Hospital Discounted Care as their Medicare benefits do not cover outpatient care.

B. Medi-Share and Health Care Sharing Ministries

Patients who participate in Medi-Share or any health care sharing ministry are considered uninsured. These programs do not guarantee payment for medical services and do not qualify as Creditable Coverage. Such patients must be screened for Hospital Discounted Care.

C. Non-Health Insurance Third-Party Payers

Patients who do not have Creditable Coverage but may have a third party responsible for some or all charges (for example, auto insurance after a car accident) are still considered uninsured. Motor vehicle or liability insurance does not qualify as Creditable Coverage. Facilities must not delay screening these patients and must follow the normal screening timelines.

D. Patients with Health First Colorado or CHP+

Patients currently enrolled in Health First Colorado or CHP+ with full benefits are not eligible for Hospital Discounted Care.

Patients with limited benefit plans (such as Emergency Medicaid, Family Planning, or the Breast and Cervical Cancer Program [BCCP]) are considered uninsured for services not covered by the limited benefit plan and must be screened for those services.

Patients who later obtain full benefits under Health First Colorado or CHP+ may apply for Hospital Discounted Care to cover services provided before their benefits began. However, Hospital Discounted Care cannot be used to cover services denied under those programs once coverage is active.

E. Patients with Current Creditable Coverage

Patients who have any form of Creditable Coverage other than Health First Colorado or CHP+ are considered insured. They must be screened for Hospital Discounted Care only if they request financial assistance.

F. Patients with Lapsed or Canceled Creditable Coverage

If it is determined that a patient did not have active insurance coverage on the date of service, the patient is considered uninsured for that date, even if they later obtain coverage.

- The Health Care Facility must screen the patient within 45 days of learning that the coverage was invalid.
- If the facility cannot reach the patient within 45 days, it must begin the six months of Screening Best Efforts (see Section 2.09) starting from the date the facility discovered that the patient was uninsured.

Section 2.02 Screening Process

Health Care Facilities are required to complete a screening or collect a Decline Screening form for each unrelated episode of care for a patient who is uninsured, unless the patient has an unexpired Hospital Discounted Care determination or they are currently in the process of completing a Hospital Discounted Care application.

The screening for Hospital Discounted Care begins when a patient or their guardian provides the Health Care Facility with the information necessary to complete the first page of the Uniform Application, available on the Hospital Discounted Care website. The screening helps the Health Care Facility determine whether the patient is likely eligible for financial assistance or public health coverage programs.

Information Collected During Screening

Health Care Facilities must complete the screening using self-attested information provided by the patient. Facilities may ask about:

- Household size, and
- Household income.

Facilities must not ask about assets or the value of any assets.

The screening process is considered complete once the patient has either:

- Completed the screening, or
- Signed a Decline Screening form.

Language Access Requirements

Health Care Facilities must offer the screening in the patient's preferred language and provide a qualified interpretation service, if needed. A family member may only interpret if the patient requests it, after being offered a professional interpreter.

During screening, the facility must also provide the Patient Rights document created by the Colorado Department of Health Care Policy & Financing (HCPF), available on the Hospital Discounted Care website.

Notification of Programs and Assistance

After completing the screening, the facility must inform the patient of:

- Any programs or discounts they appear eligible for and how to apply; and
- Financial assistance options available through Connect for Health Colorado, the state's health insurance marketplace.

Section 2.03 Decline Screening Policy and Form

Patient Right to Decline

Patients have the right to refuse screening for public health coverage and/or Hospital Discounted Care. When a patient declines, the Health Care Facility must have the patient complete the state-approved Decline Screening Form and keep a copy on file. The official Decline Screening Form is available on the Hospital Discounted Care website in English and Spanish. Once the Decline Screening Form is completed, the screening process is considered finished for that patient for the date(s) of service indicated on the form only, which can only include past dates.

Reconsidering a Decline Decision

A patient's decision to decline screening is not permanent. An uninsured patient who previously declined may still request screening and apply for discounted care at any time within at least 181 days of the date of service or discharge, whichever is later.

Completing the Decline Screening Form

The Decline Screening Form must be completed whenever an uninsured patient chooses not to be screened. Decline Screening Forms are not required for and should not be requested from insured patients. Best practice is to have the uninsured patient sign the form, either physically or electronically, at the time they decline.

If the patient verbally declines - whether during scheduling, intake, or as part of the facility's Screening Best Efforts follow-up - this still counts as a valid decline. In such cases, the Health Care Facility must still complete the Decline Screening Form.

The staff member (enrollment specialist, financial counselor, or other designated employee) must record:

- The date and time of the verbal decline,
- The reason given for declining (if any), and
- Their own signature on the form.

Whenever possible, a second staff member should sign as a witness that the patient verbally declined and did not wish or was unable to sign the form.

Record Retention

Health Care Facilities must retain each signed Decline Screening Form until June 30 of the seventh state fiscal year after the patient's date of service or discharge, whichever is later.

Coverage of a Decline Form

A Decline Screening Form generally applies only to one episode of care and any related services. It may also apply to past dates of service if those dates are specifically listed or included within a stated date range on the signed form.

A Decline Screening Form cannot be used for future services that are unrelated to the original episode of care. However, a form may be collected during scheduling or intake for a planned service, and it would cover that specific service and any related services that fall under the same episode of care.

Each Health Care Facility must use the same definition of "episode of care" for both the screening process and the creation of payment plans. In other words, any services that would fall under a single screening or Decline Screening Form must also be included in one payment plan.

Legal Protection

If a patient's decision to decline screening is properly documented and complies with the HCPF Code of Colorado Regulations, it serves as a complete legal defense under C.R.S. § 25.5-3-506(2) against claims of violation under C.R.S. § 25.5-3-506(1)(a) or (1)(b).

Section 2.04 Screening Timeline

A. Uninsured Patients

Health Care Facilities must complete a screening or collect a signed Decline Screening Form for all uninsured patients, even if they:

- Appear to have income above eligibility thresholds, or
- Are non-Colorado residents.

This must occur within 45 calendar days of the patient receiving services at the Health Care Facility.

Patients may complete a screening at any time within at least 181 days after their date of service or discharge, whichever is later - even if they previously signed a Decline Screening Form. Screenings and applications may also be completed during scheduling, intake, or at any time before the scheduled service.

B. Insured Patients Who Request Financial Assistance

Health Care Facilities must complete a screening for any insured patient who requests financial assistance, even if the patient does not specifically ask for "Hospital Discounted Care."

- The facility must contact the patient or guardian within three business days of receiving the request to complete or arrange the screening.
- The screening itself must occur within 45 days of the date the patient requested it.

C. Timing Windows for Insured Patients

Insured patients may request screening before or after receiving services.

1. Pre-Service Requests

Patients may request to be screened before receiving scheduled services.

2. Post-Service Requests

After services are provided, insured patients have two opportunities to request screening:

First window:

- The same as uninsured patients - at least 181 days from the date of service or discharge, whichever is later.

Second window:

- At least 45 days from the date of the first bill after the patient's insurance adjustment, even if that date falls outside the normal 181-day window.

Examples:

- If the first post-insurance bill is dated 170 days after the date of service or discharge, the patient has until at least day 215 (170 + 45 days) to request financial assistance.
- If the first post-insurance bill is dated 200 days after the date of service or discharge, the patient has until at least day 245 (200 + 45 days) to request financial assistance and begin the screening process.

Section 2.05 Screening Best Practices

Health Care Facilities should make every reasonable effort to complete screenings before a patient leaves the facility, particularly when it is known that the patient may be experiencing homelessness or may be difficult to reach later. Screenings may occur before scheduled services, during admission, or prior to discharge, depending on the patient's condition and circumstances.

Although facilities have 45 days to complete the screening, staff should ensure that patients are in a stable and coherent condition before completing the screening or signing a Decline Screening Form. In some cases, a patient may not be ready to make financial or consent decisions until at least 24 hours after discharge.

Patients and, when applicable, their guardians, medical power of attorney, or caregivers should be informed of the right to be screened before leaving the facility. If screening cannot be completed during the visit, the facility should schedule a screening appointment for a later date. Ideally, the scheduling of the screening appointment should occur before the patient is discharged or departs the facility.

Section 2.06 Completing the Screening

Overview

Screenings are completed by answering all questions in the Screening Form tab of the Uniform Application, using self-attested information provided by the patient or their guardian. Health Care Facilities must not require documentation to complete a screening.

Facilities that use other screening tools may do so only if those tools collect all required screening information from the Screening Form tab. Screenings should note the date the screening was completed as well as the date(s) of service the screening is being completed to cover. All responses must be kept in an auditable format.

Facilities must retain screening forms until June 30 of the seventh state fiscal year after the patient's date of service or discharge, whichever is later.

Patient Notification

After completing the screening, the Health Care Facility must:

- Inform the patient of the screening results, and
- Provide information about how to apply for public health coverage or Hospital Discounted Care, regardless of the result.

For details about the formal Notice of Determination, see Section III: Application and Determination Notice, Article 2: Notice of Determination.

Information Required in Each Section of the Screening

1. Responses Provided by Eligibility Technician

Each screening must include:

- Name of the technician completing the screening
- Name and phone number of the hospital
- Date the screening is completed
- Earliest date of service the household seeks to cover

When using the Uniform Application, these fields are automatically entered into the Patient Information tab.

---

2. Patient Contact Information

The patient or guardian must provide:

- Patient’s name
- Household address
- Phone number and/or email (if available)
- Preferred method of contact
- Whether the household is experiencing homelessness

Patients experiencing homelessness are not required to provide documentation to complete the application. Whenever possible, complete the full application at the time of screening for these patients.

---

3. Patient Demographic Information

The patient or guardian must provide the patient's date of birth. This information helps determine possible eligibility for age-based programs such as Child Health Plan *Plus* (CHP+) for minors or Medicare for older adults.

---

4. Patient Residency

Hospital Discounted Care is generally available to Colorado residents. Patients who were Colorado residents at the time of their services but have since moved out of state can complete applications to cover only their outstanding date(s) of service.

If the Health Care Facility does not extend eligibility to non-residents, the screening may be considered complete once all questions are answered through the Colorado residency section.

If a patient is not a Colorado resident but has Medicaid coverage in another state, facilities are strongly encouraged to enroll in that state's Medicaid program to obtain payment for care. Facilities may also choose to extend Hospital Discounted Care to out-of-state Medicaid patients.

---

5. Pregnancy and Children (Optional)

These questions help identify whether the patient or any minor household members may qualify for Health First Colorado or CHP+, once income information is entered later in the screening.

---

6. Disabilities

These questions identify whether the patient may qualify for a Health First Colorado program for individuals with disabilities, which may have different income limits. Patients reporting disabilities should be encouraged to apply for Health First Colorado to determine eligibility. This section also helps identify potential Medicare eligibility.

---

7. Patient Insurance Status and Benefits

This section determines whether the patient currently has insurance and collects any Health First Colorado ID number if the patient has current or prior coverage.

If the patient can provide an ID number, staff should verify whether coverage is active. Providing the ID number is not required to complete the screening but may make further screening unnecessary if active coverage is confirmed. Health First Colorado coverage status can be checked through the Provider Portal. Facilities can use the Benefit Plan and Program Aid Code webpage to determine what kind of Health First Colorado coverage a patient currently has.

8. Household Size and Household Income

This section captures income and household details for the patient and each household member. It is important to complete all required questions for each person added to the application. If someone in the household is pregnant, the unborn child(ren) must be included to ensure the household size is accurate.

For each household member:

- Relationship to the patient – used to determine household composition for eligibility under both Hospital Discounted Care and Health First Colorado/CHP+.
- Income – used to calculate the household's estimated Federal Poverty Guideline (FPG) percentage.
- Tax status – identifies who should be counted in the household for Health First Colorado/CHP+, ensuring accurate FPG estimates.

9. Facility Deductions

If the Health Care Facility applies deductions when determining income, those may be entered during the screening to more accurately estimate the household's eligibility for Hospital Discounted Care.

FPG Calculations and Screening Results

At the bottom of the Screening Form tab, the Uniform Application automatically calculates household size and FPG percentage in three ways. Eligibility technicians must review each calculation to ensure it aligns with expectations.

1. Full Household (as entered): Includes all members and their income.
    - If the household FPG is 250% or less, the screening result under *Hospital Discounted Care* will show "Likely eligible."
2. Health First Colorado Definition: Uses the household defined by tax return members.
    - This is not an official Medicaid determination, but an estimate.
    - Screening will show:
        - "Likely eligible" for Health First Colorado if the household FPG is 138% or less (133% + 5% disregard).
        - "Likely eligible" for pregnant patients if the household FPG is 200% or less (195% + 5% disregard).

- "Likely eligible" for CHP+ if the household FPG is 260% or less, the household includes minors or a pregnancy, and the household is uninsured.

3. Hospital Discounted Care: Excludes non-spouse, non-minor adults if their income causes the patient to exceed 250% FPG and excluding them would make the patient eligible.
    - If so, the result will display "Likely eligible, count spouse and/or children only."

If a patient could qualify for Hospital Discounted Care by applying separately from other household members (other than a spouse or civil union partner, who must always be included), the facility must inform the patient and allow them to apply separately. This provision does not apply to non-emancipated minors.

Patients should be advised that including any minor children under their care generally improves eligibility by increasing household size and lowering the calculated FPG percentage.

The Screening Results section will also display potential Medicare eligibility if the patient is 65 or older or if the patient answered "Yes" to any disability question.

Section 2.07 Hospital Presumptive Eligibility

Presumptive Eligibility is a program that gives some patients immediate, temporary Health First Colorado or CHP+ coverage. During a screening for Hospital Discounted Care, a Health Care Facility that has been certified as a Hospital Presumptive Eligibility site by HCPF may simultaneously complete a presumptive eligibility screening for any patient who agrees to complete the presumptive eligibility screening. Facilities may not require a patient to complete a presumptive eligibility screening prior to, during, or after their Hospital Discounted Care screening. A presumptive eligibility screening cannot be completed in lieu of the Hospital Discounted Care screening required under C.R.S. 25.5-3-502.

If a patient is determined to be presumptively eligible during their screening, the Hospital Presumptive Eligibility site may require the patient to complete the application process for Health First Colorado/CHP+. The patient may be denied Hospital Discounted Care for the date of service the presumptive eligibility would apply to, but facilities may allow patients to apply for Hospital Discounted Care if the patient states they do not want to complete the Health First Colorado/CHP+ application process.

Facilities interested in becoming a Hospital Presumptive Eligibility site or who have questions about Hospital Presumptive Eligibility can send their questions to hcpf_PE.Eligibility@state.co.us.

Section 2.08 Patients with a Pending Health First Colorado or CHP+ Application

Patients may receive hospital services while their Health First Colorado or CHP+ application is pending.

A. When the Facility Knows About the Pending Application

If a patient notifies the Health Care Facility before screening that they have a pending Health First Colorado or CHP+ application, the facility may choose to wait to complete the Hospital Discounted Care screening until after the state application has been processed.

If the facility learns during the screening that a patient has a pending application, the facility must still:

- Communicate the screening results to the patient, but
- May defer completing a full Hospital Discounted Care application until the state's determination is issued.

During this period, the facility must track the status of the patient's Health First Colorado or CHP+ application either by checking with the state system or following up directly with the patient.

B. If the Patient Is Found Ineligible

If the patient's Health First Colorado or CHP+ application is denied, and a Hospital Discounted Care screening has not yet been completed, the facility must:

- Complete the screening within 45 days of the date the facility is notified of the denial.

If the facility is unable to contact the patient within those 45 days, it must begin the Screening Best Efforts process and continue outreach until either contact is made or 182 days have passed from the denial date.

C. Patients Who Are Approved for Health First Colorado or CHP+

Patients who are approved for full benefits under Health First Colorado or CHP+ are not eligible for Hospital Discounted Care. Patients who are approved for limited benefits under Health First Colorado are eligible for Hospital Discounted Care for services that are not a covered benefit of the Health First Colorado program they qualified for.

Hospital Discounted Care cannot be used as secondary coverage for any services already covered under these programs.

Section 2.09 Screening Best Efforts

When a patient is discharged or otherwise leaves the Health Care Facility without completing a screening or signing a Decline Screening Form, the Health Care Facility must make reasonable efforts to contact the patient to complete screening.

A. Outreach Requirements

Health Care Facilities must attempt to contact the patient using at least one method of communication. If the patient has identified a preferred method of contact, the facility should use that method for the initial outreach when feasible. Acceptable methods of contact include phone calls, SMS messages, emails, patient portal messages, and mailed correspondence.

The first outreach attempt must occur prior to the 46th day following the patient's date of service or date of discharge, whichever is later. Facilities should continue outreach efforts at least monthly for six months following the patient's date of service or date of discharge, whichever is later. Outreach efforts for the date of service may cease once the patient has completed a screening or signed a Decline Screening form covering that date of service. Efforts must begin again with each new date of service for which the screening requirement applies.

Repeated use of the patient's preferred method of contact, when available, is considered a best practice. Inclusion of the Patient Rights document within a billing statement after the initial outreach attempt may be considered a screening contact attempt.

Documentation of outreach and communication attempts maintained in the patient's record satisfies the Screening Best Efforts requirement.

B. Billing During Screening Outreach

Billing statements may be issued beginning 46 days after the patient's date of service or date of discharge, whichever is later, when screening has not been completed or scheduled.

Statements may be sent prior to the 46th day if the patient requests a statement in order to determine whether they wish to pursue screening for discounts. The patient's request must be documented. Patients must not be required to decline screening in order to receive a billing statement.

C. Patient Requests to Stop Outreach

If a patient requests that the Health Care Facility stop contacting them regarding screening, the facility may consider screening requirements fulfilled. The patient's request must be documented and retained as part of the patient's record.

D. Informed Decline Due to Nonresponse

If a Health Care Facility has made documented outreach attempts consistent with this section and the patient does not respond within 181 days of the patient's date of service or date of discharge, whichever is later, the facility may consider the nonresponse to be an informed decision to decline screening.

Outreach communications must inform the patient that failure to respond may result in the loss of the opportunity to be screened for cost-saving options.

At a minimum, documented outreach efforts must include reasonable attempts to contact the patient using available contact information, which may include:

- calling phone numbers provided by the patient and leaving voicemail messages containing only information permitted under the Health Insurance Portability and Accountability Act and the Telephone Consumer Protection Act;
- sending SMS messages to patient-identified mobile numbers, if the Health Care Facility has the capability to do so;
- sending emails to any email address provided by the patient; and
- sending messages through an available patient portal.

Section 2.10 Accounts of Deceased Patients

When a patient passes away prior to completing screening, the Health Care Facility must ensure that information about Hospital Discounted Care screening is made available to the appropriate representative of the patient.

If the patient was uninsured at the time services were provided, the Health Care Facility must provide the Patient Rights document to the patient's spouse, guardian, power of attorney, executor of the estate, or other legally authorized representative. The Patient Rights document may be provided in person, in writing, or verbally.

If the Health Care Facility does not have contact information for a legally authorized representative or next of kin, the facility may proceed with an estate search. Once an executor of the estate or next of kin is identified, the facility must offer screening and/or application for Hospital Discounted Care.

A family member or other authorized representative may complete the screening and application process on behalf of the deceased patient or may sign a Decline Screening Form. Completion of screening, application, or a Decline Screening Form by a representative does not make that individual financially responsible for the deceased patient's medical bills. Financial responsibility remains with the individual or entity legally responsible for the patient's estate.

Health Care Facilities may complete an application on behalf of a deceased patient only as a last resort, when no legally authorized representative or next of kin can be identified despite reasonable efforts, and solely for the purpose of completing required screening obligations prior to writing off the account.