



<b>Title:</b> Patient Financial Assistance and Discount Payment Program		<b>Number:</b> L3003
<b>Manual:</b> Administrative	<b>Section:</b> Finance	<b>Effective Date:</b> 08/25/2025

**I. PURPOSE:**

- A.** For the purposes of the Patient Financial Assistance and Discount Payment Program Policy, CHOC Enterprise refers to the collective network of healthcare organizations, services, and providers affiliated with CHOC. CHOC Enterprise includes the following entities:
1. CHOC Hospital – The main pediatric hospital located in Orange, California, providing specialized medical services and care for children.
  2. CHOC at Mission Hospital – A healthcare facility located within Providence Mission Hospital located in Mission Viejo, California, offering pediatric care and specialized services.
  3. CHOC Specialist – A group of pediatric specialists providing expert care in various pediatric subspecialties across the CHOC network.
  4. CHOC Primary Care Network – A network of primary care providers affiliated with CHOC, offering comprehensive healthcare services to children from birth through adolescence.
- Together, these entities form the CHOC Enterprise (hereafter referred to as CHOC), which provides high-quality pediatric care across various specialties and locations, and which is subject to the terms and conditions set forth in this Financial Assistance Policy.
- B.** CHOC is committed to providing quality healthcare to all patients regardless of the patient’s financial status. Patients who meet the established Financial Assistance Program criteria may be eligible to receive Financial Assistance to cover all or portions of the patient’s healthcare costs. To apply for Financial Assistance please go to our website ([www.CHOC.org/patients-family/pay-bill](http://www.CHOC.org/patients-family/pay-bill)). CHOC also provides benefits for the broader community in terms of medical education and medical research.
- C.** Under this policy, Financial Assistance may be provided to patients who are uninsured or underinsured and cannot afford to pay for their own medical care of out of pocket expenses. Eligibility for the Financial Assistance Program shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, disability or religion.
- D.** In some cases, Financial Assistance may be extended to patients whose financial status makes it impractical or impossible to pay for necessary medical services. The evaluation of the necessity for medical treatment at CHOC will be based upon clinical judgment. The clinical judgment of the patient’s physician or the Emergency Department staff physician will be the sole determining criteria for patient’s receiving services at CHOC.
- E.** This policy is applicable to all CHOC Inpatients and Outpatients, including CHOC Medical Foundation. CHOC bases the eligibility for our Financial

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Assistance off of current Financial Applications. CHOC does not look to outside sources for FAP eligibility or determination.

## II. DEFINITIONS:

- A. Patient Data:** Medical record number, patient name, birth date, insurance status, eligibility for other support.
- B. Patient's family:** For purposes of this policy is as follows:
  1. For persons 18 years of age and older, spouse, domestic partner as defined in Section 297 of the California Family Code; and dependent children under 21 years of age, or any age if disabled, whether living at home or not;
  2. For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

## III. POLICY:

- A.** It is the policy of CHOC to determine eligibility for Financial Assistance at the time of registration, through a financial screening process for all patients not able to meet the deposit requirements of CHOC.
- B.** This policy distinguishes a bad debt patient from an eligible Financial Assistance patient by the patient's or patient's family unwillingness to pay versus a demonstrated inability to pay. Failure of the patient and/or patient's family to comply with requests for information to substantiate an inability to pay may result in forfeiture of the right to be considered for the Financial Assistance Program.
- C.** It is the goal of CHOC to identify an eligible Financial Assistance patient at the time of registration; however, if complete information regarding the patient's insurance or financial situation is unavailable due to emergency treatment, or if the patient's/guarantor's or patient family's financial condition changes, the designation as a Financial Assistance patient may be established after the rendering of services, and in some instances even after the production of a patient bill.
- D.** Should a staff physician or clinician wish to prospectively pursue Financial Assistance for a known patient, the protocol for requesting Financial Assistance can be found on Paws located under the on-line form bank.
- E.** Confidentiality of information and the dignity of the patient will be maintained for all that seek or are provided Financial Assistance services.
- F.** Patients receiving services in the Hospital Emergency Room will also be eligible for Financial Assistance in paying for the Emergency Room physician fees. The Emergency Room physician billing company will rely on the hospital's determination of FAP eligibility as required by Health and Safety Code section 127405(a)(1)(B).
- G.** Below is a list of providers, other than the hospital itself, that provide medically necessary care in the hospital. For convenience they are listed by category of care. The list indicates whether the providers are covered by the hospital's FAP.

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<b>Medical Specialty/Department</b>	<b>Covered Under Hospital FAP</b>	<b>Not Covered Under Hospital FAP</b>
Allergy and Immunology	x	
Anesthesiology		x
Cardiovascular Diseases	x	
Dental		x
Diagnostic Radiology	x	
Emergency Department		x
Gastroenterology	x	
General/Family Practice	x	
General Surgery		x
Internal Medicine	x	
Neurological Surgery		x
Neurology	x	
Obstetrics & Gynecology	x	
Occupational Medicine	x	
Oncology	x	
Ophthalmology	X	
Surgeons All		x
Otolaryngology	x	
Pathology		x
Pediatrics	x	
Physical Medicine/Rehab	x	
Plastic Surgery	x	
Podiatry		x
Pulmonary Diseases	x	
Therapeutic Radiology	x	
Thoracic Surgery		x
Urology	x	
Other: Psychiatry	x	
Other: Clinical Genetics	x	
Other: Dermatology	x	
Other: Endocrinology	x	
Other: Hematology	x	
Other: Hospitalists	x	
Other: Infectious Disease	x	
Other: Neonatology	x	
Other: Nephrology	x	
Other: Rheumatology	x	
Other Sleep Medicine	x	

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#### IV. PROCEDURE:

##### A. Eligibility

1. The identification of Financial Assistance is achieved through determination of the financial status of a patient or patient's family. Such determination should be made at or before the time of registration, or as soon thereafter as is possible. In some cases, such as emergency admissions, it may not be possible to establish eligibility for the Financial Assistance Program until after the patient is discharged. In these instances, or instances where events occur during or after a patient's stay which change the patient's or patient family's financial status, the patient's eligibility for the Financial Assistance Program shall in no way be affected by the timing of the determination that the patient meets the eligibility criteria.
2. The responsibility for identifying a patient's eligibility for the Financial Assistance Program at, or before, the time of the patient visit to CHOC shall be the responsibility of the department registering the patient. This will require the patient or patient's family to complete a "Financial Disclosure" statement. This may also include copies of pertinent documentation (recent pay stubs, income tax returns or other documents) to determine the annual family income of the patient or patient's family. In those instances, described above, where eligibility cannot be established at the time of service, the Patient Financial Services Department shall work with the patient or family to determine eligibility.
3. Patient or patient's family having insurance may also be eligible for the Financial Assistance Program for that portion of the bill not covered by insurance. This may include deductibles, coinsurance, and non-covered services. The determination of a patient's eligibility shall be subject to the same guidelines as an uninsured patient.
4. Patient, whether uninsured or insured, who has High Medical Cost may be eligible for the Financial Assistance program. This included patients with annual out of pocket cost incurred by the patient at the Hospital exceeding 10% of the Family Income in the prior 12 months. Out-of-pocket costs means any expenses for medical care that are not reimbursed by insurance or a health coverage program.
5. Qualification Period.
  - a. Patients determined to be eligible may be granted Financial Assistance for period of six months.
6. **Calculating the amount of Financial Assistance.**
  - a. CHOC will obtain information on the patient's family income, including wages and salary, welfare payments, social security payments, strike benefits, unemployment benefits, child support, alimony, dividends and interest. The total family income will be compared with the table (see Schedule A) to determine a patient's eligibility for Financial Assistance under the Federal Poverty

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Guidelines. Any uninsured patients or patients with high medical costs whose annual household income is at or below 550% of the Poverty Guidelines shall be eligible to apply for Financial Assistance. Financial Assistance may be considered on a partial basis for patients with incomes more than 400% of Poverty Guidelines and less than 550%.

- b. Those families with an annual income of 400% or less of the Federal Poverty Guidelines would be eligible for a 100% Financial Assistance adjustment. Uninsured or underinsured patients whose household income, as determined in accordance with the Assistance Application, is less than or equal to 400% of the poverty guidelines, will receive care, free of charge.
- c. In providing charity care, CHOC is required by law to consider the amounts generally billed to individuals who have insurance covering emergency or other medically necessary care (“Amounts Generally Billed” or “AGB”) and to guarantee that patients accepted for charity care will not be charged more than AGB for other medically necessary services.
- d. CHOC Community Clinic patients are eligible for Financial Assistance as outlined in this policy utilizing Schedule B to calculate the sliding scale per visit co-pay for patients falling below 200% of the Federal Poverty Guidelines.
- e. Patients applying for Financial Assistance and who are receiving full or partial approval will have their approval for assistance forwarded to the Emergency Room physician billing company. The Emergency Room physician billing company will rely on the hospital’s determination of FAP eligibility as required by Health and Safety Code section 127405(a)(1)(B).

7. **Discount Payment Policy**

- a. For patients with household incomes between 401% and 450% of the Federal Poverty Level, the Hospital may provide a discounted Private Pay Fee Schedule, whereby the allowable medical expense would be equivalent to a 75% discount off billed charges. At this level, the reimbursement CHOC would receive shall not exceed the payment that CHOC would receive for the same service or set of services from the greater of Medicare or Medi-Cal.
- b. For uninsured patients with household incomes between 451% and 550% of the Federal Poverty Level, CHOC may provide a discounted Private Pay Fee Schedule, whereby the allowable medical expense would be equivalent to a 50% discount off billed charges. At this level, the reimbursement that CHOC would receive shall not exceed the payment that CHOC would receive for the same service or set of services from the greater of Medicare or Medi-Cal.

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8. CHOC Financial Assistance Program Eligibility Guidelines are based on the most recently published Federal Poverty Guidelines. Schedule A delineates the household income thresholds according to the Federal Poverty Guidelines, published annually.

9. **Monthly Payment Plan Eligibility**

- a. Any patient or patient's family that qualifies and is approved under the Financial Assistance Program for a partial discount of charges will also be eligible to make monthly payments. CHOC and the patient's family may negotiate the terms of the payment plan. If an agreement between the patient's family and CHOC cannot be reached, the patient's family will be required to complete a CHOC FAP extended payment plan form (Schedule C). Upon receipt of this completed form, CHOC will evaluate the total monthly income of the family minus family essential living expenses. A monthly payment plan will then be offered to the family at a rate not to exceed 10% of income minus essential living expenses. During the approved repayment period, CHOC will apply no interest to the discounted account balance.
- b. An extended discount payment plan could be declared inoperative after the patient or patient's family fails to make consecutive payments due during a 90 day period. Prior to declaring an extended payment plan inoperative, CHOC, or its collection agency, or assignee must make a reasonable attempt to notify the patient or patient's family by phone or at last known phone number and in writing at the last known address, that the extended payment plan may become inoperative and there might be an opportunity to renegotiate if requested by the patient or patient's family.

**B. Exceptions:**

1. It is understood that extenuating circumstances will arise that might require special consideration in approving Financial Assistance for patients who do not meet the established criteria. CHOC representatives should be aware of this when evaluating individual patient cases for the Financial Assistance Program. While it is not possible to provide a definitive or complete listing of all extenuating circumstances that may arise, some important factors to consider would include:
  - a. The amount owed by the patient or patient's family in relation to his/her total income. If the total patient out of pocket expenses at CHOC exceed 10% of the patient's or patient family's annual income for the prior 12 months.
  - b. The medical status of the patient or of his/her family's provider.
  - c. The patient's or patient family's willingness to work with CHOC in exhausting all other payment sources.
2. Any circumstances that are considered to fall into the "extenuating circumstances" category should be brought to the attention of the Director

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of Patient Financial Services. Cases falling into this category may require the approval of the Vice President of Finance or Chief Financial Officer.

**C. Financial Assistance Program Approval/Denial/Appeal Process**

1. Any patient account recommended for partial or total Financial Assistance adjustment, after meeting the guidelines set forth in this policy require the following signature approval process to be followed:

**a. CHOC (Hospital and Clinics)**

Up to \$2,000	Revenue Cycle Associate
Up to \$10,000	Revenue Cycle Division Supervisor
Up to \$50,000	Revenue Cycle Division Manager
Up to \$100,000	Revenue Cycle Division Director
Up to \$250,000	Senior /Executive Director
Up to \$1,000,000	Vice President of Revenue Cycle
Over \$1,000,000	Chief Financial Officer

**b. CHOC Medical Foundation**

Up to \$2,000	Revenue Cycle Associate
Up to \$10,000	Revenue Cycle Division Supervisor
Up to \$50,000	Revenue Cycle Division Manager
Up to \$100,000	Revenue Cycle Division Director
Up to \$250,000	Senior/Executive Director
Up to 1,000,000	Vice President of Revenue Cycle
Over \$1,000,000	Chief Financial Officer

2. At the time a decision is made to approve or deny a patient account for the Financial Assistance Program, a letter will be sent to the patient as a notification of the decision made. If an application for the Financial Assistance Program is denied, a CHOC representative will contact the patient or patient's family to make payment arrangements on the account.
3. **Appeal Process:**  
If at any point in the Financial Assistance approval process the application is in dispute, the patient or patient's family has the right to request reconsideration of the application at the next level of the approval process. The final determination for denial of Financial Assistance will reside solely with the Executive Vice President and Chief Financial Officer, and their determination will be considered final.
4. Patient or patient family's appeal must be submitted in writing to the Patient Accounting Director within thirty (30) days of notification of original denial.
5. Provision of the Financial Assistance Program does not eliminate the right to bill, either retrospectively or at the time of service, for all services, when fraudulent, inaccurate or incomplete information has been given in the

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application process. In addition, CHOC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those who have provided false, inaccurate or incomplete information in order to qualify for the Financial Assistance Program.

**D. Financial Assistance Program: Notification to Patient or Patient’s Family**

1. CHOC patient statements will provide notification advising the patient of CHOC Financial Assistance Program policy, and the contact information to obtain additional information about assistance. This notification shall include a tagline sheet with the following statement provided in English and in the top 15 languages spoken by limited-English-proficient (LEP) individuals in California as determined by the State Department of Health Care Services. “ATTENTION: If you need help in your language, please call [phone number where patients may obtain more information]. The office is open [offices hours] and located at [office location information]. Aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available. These services are free”. In addition, all patient statements will include information on how the patient’s family can obtain information about the California Health Benefit Exchange, as well as county and state funded health plans. Hospital will have applications for state and county plans available for distribution.
2. A summary of the Financial Assistance Program along with contact information shall be posted in both English and Spanish in high traffic areas of CHOC, such as Admitting, Emergency Room, Clinics, Outpatient Registration and Patient Accounting Offices.
3. CHOC will provide to all self-pay patients at point of service, notice of the Financial Assistance Program and contact information, as well as information about government sponsored programs and contact information about the California Health Benefits Exchange.

**E. Collection Process:**

1. If a patient qualifies for assistance under the Financial Assistance Program and is making every effort to settle an outstanding bill within a reasonable time period, CHOC or its agent shall not send, nor intimate that it will send, the unpaid account to an outside agency if doing so may negatively impact a patient’s credit. If CHOC is forced to send the account to an outside collection agency, the amount referred to the agency shall reflect the reduced payment level for which the patient was eligible under the Financial Assistance Program. CHOC will not engage in any extraordinary collection efforts. In the event the patient makes payments on their CHOC account in excess of total amount of patient responsibility, CHOC will refund any over payment to the patient with interest accrued at the rate set forth in existing law beginning on the date the hospital receives patient payment and it is identified as a patient credit. CHOC, however, is not required to reimburse the patient or pay interest if the amount owing is under \$5.00. The hospital



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will recognize the \$5.00 credit for a minimum of 60 days against any patient balance incurred during that period of time.

2. CHOC shall not, in dealing with identified uninsured patients at or below 400% of the Federal Poverty Level, use wage garnishments or liens on patient's or patient family's primary residence as a means of collecting unpaid CHOC bills. This requirement does not preclude CHOC from pursuing reimbursement from third party liability settlements.

**F. Documentation for Financial Assistance Program Discounts**

In cases where it has been determined that a patient qualifies for the Financial Assistance Program, it is important that the patient's file be properly documented in order to facilitate easy identification of the patient, as well as to maintain a proper record of the facts that resulted in the determination of the eligibility for Financial Assistance. The minimum documentation that may be required for each Financial Assistance case may be limited to one of the following:

1. Copy of the patient's or patient family's completed Financial Disclosure Worksheet, including any supporting documentation to same (i.e., prior year tax returns (preferred documentation), W-2 Forms, or current pay stubs).
2. Copies of additional documentation, notes, etc. that outline extenuating circumstances that were considered in the determination of eligibility for the Financial Assistance Program (if available or needed).
3. A copy of the "Approval for Financial Assistance" signed by the appropriate Hospital representative(s) (if available).
4. Bankruptcy within the last year (automatic qualification for the Financial Assistance Program).

**G. Reports**

Financial Assistance shall be logged with the following information:

1. Patient data consisting of Protected Health Information (PHI) will be maintained in a manner that protects the privacy and confidentiality of such information and will only be logged as necessary for implementation of the Financial Assistance Program.
  - a. Inpatient or outpatient status
  - b. Total patient charges
  - c. Financial Assistance expenditures, approved and denied
  - d. Date of approval/rejection
  - e. Rationale for any rejection
2. All application files are confidential and will be maintained in a secure location for a minimum of three years after the date of the application and the completion of CHOC fiscal yearend audit. All Financial Assistance Program logs will be maintained for a period of seven (7) years. At the end of the respective period, all information will be destroyed or maintained in a manner to protect the privacy and confidentiality of the patient.

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3. This policy cannot be modified to remove or lessen benefits for recipients. Any proposed changes to this policy must be approved in advance by the Compliance Department.

#### V. REFERENCES:

- A. Revenue Cycle Management, Zimmerman and Associates. December 2002.
- B. California Hospital Association, Voluntary Principles and Guidelines for Assisting Low-Income Uninsured Patient February 06, 2004.
- C. American Hospital Association, Statement of Principles and Guidelines on Hospital Billing and Collection Practices, April 27, 2004.
- D. Assembly Bill 774 Chan-Hospitals: fair pricing policies.
- E. California Hospital Association, Charity Care Requirements Implementation AB 774 November 3, 2006.
- F. Barclays California Code of Regulations, Title 22, Chapter 7, Section 75049.
- G. Department of Health and Human Services, Federal Poverty Income Guidelines. <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>
- H. Health Center Program Statute: Section 330 of the Public Health Services Act (42 U.S.C. 254b).
- I. Program Regulations 42 code of Federal Regulations (CFR) Part 51c and 42 CFR Parts 56.201-56.604 for Community and Migrant Health Centers CDPH Issue AFL Related to California Hospital Fair Pricing Policies, November 5, 2014.

#### POLICY CONTRIBUTORS, APPROVALS, AND HISTORY

Policy Contributors	
Facilitator:	Manager, Patient Accounts
Policy Collaborators:	
Department Head:	Executive Director Revenue Cycle
Executive Management Team Member:	Ken Baxter, Vice President Revenue Cycle

**Schedule A**

<b>Published Federal Poverty Guidelines for 2025</b>				
<b>Number in Household</b>	<b>Up to 100%</b>	<b>Up to 400%</b>	<b>Up to 450%</b>	<b>Up to 550%</b>
<b>1</b>	<b>\$15,650</b>	<b>\$62,600</b>	<b>\$70,425</b>	<b>\$86,075</b>
<b>2</b>	<b>\$21,150</b>	<b>\$84,600</b>	<b>\$95,175</b>	<b>\$116,325</b>
<b>3</b>	<b>\$26,650</b>	<b>\$106,600</b>	<b>\$119,925</b>	<b>\$146,575</b>
<b>4</b>	<b>\$32,150</b>	<b>\$128,600</b>	<b>\$144,675</b>	<b>\$176,825</b>
<b>5</b>	<b>\$37,650</b>	<b>\$150,600</b>	<b>\$169,425</b>	<b>\$207,075</b>
<b>6</b>	<b>\$43,150</b>	<b>\$172,600</b>	<b>\$194,175</b>	<b>\$237,325</b>
<b>7</b>	<b>\$48,650</b>	<b>\$194,600</b>	<b>\$218,925</b>	<b>\$267,575</b>
<b>8</b>	<b>\$54,150</b>	<b>\$216,600</b>	<b>\$243,675</b>	<b>\$297,825</b>
<b>Discount</b>	<b>100%</b>		<b>75%</b>	<b>50% Uninsured Patients</b>

## Schedule B

<b>Sliding Fee Schedule</b> <b>Gross Monthly Federal Poverty Level (FPL) Income Guidelines</b> By Family Size - Effective 2025			
<b>Health Plan Code</b>	<b>Primary Care Charity</b>	<b>Self-Pay - Special arrangements</b>	<b>Self-Pay</b>
<b>FPL Guideline</b>	<b>100% or Under</b>	<b>101% - 200%</b>	<b>Above 200%</b>
<b># persons / family</b>			
<b>1</b>	\$0-\$1,304	\$1,305 -\$2,608	Above \$2,609
<b>2</b>	\$1,763	\$1,764 - \$3,525	Above \$3,526
<b>3</b>	\$2,221	\$2,222 - \$4,442	Above \$4,443
<b>4</b>	\$2,679	\$2,680 - \$5,358	Above \$5,8359
<b>5</b>	\$3,138	\$3,139 - \$6,275	Above \$6,276
<b>6</b>	\$3,596	\$3,597 - \$7,192	Above \$7,193
<b>7</b>	\$4,054	\$4,055 - \$8,108	Above \$8,109
<b>8</b>	\$4,513	\$4,514 - \$9,025	Above \$9,026
<b>CMG</b>	\$10 Sick Visit	\$60 New Sick Visit \$40 Established Sick Visit	\$85 Partials and Non-Well Visit
<b>Fee for Service</b>	\$0 Flu Vaccine Only Administration WCC services apply for Gateway	\$25 Flu Vaccine Only Administration WCC services apply for Gateway	\$25 Flu Vaccine Only Administration \$100 Full Well visit
<b>Breathmobile Fee for Service</b>	\$25 Office Visit \$0 Flu Vaccine Only Administration	\$25 Office Visit \$25 Flu Vaccine Only Administration	\$25 Office Visit \$25 Flu Vaccine Only Administration
<b>Labs</b>	“Bill to Patient” Unless pays at time of visit @ reduced clinic rates, then “Bill to Clinic”	“Bill to Patient” Unless pays at time of visit @ reduced clinic rates, then “Bill to Clinic”	“Bill to Patient” (receives bill from lab/radiology @ regular rates)
<b>Radiology</b>	“Bill to Patient”	“Bill to Patient”	“Bill to Patient” (Receives bill from Radiology @ regular rates)
<b>Prescription Meds</b>	Prescription given Patient pays	Prescription given Patient pays	Prescription given Patient pays
<b>Supplies</b> (i.e. spacers, crutches)	From clinic stock depending on need	From clinic stock depending on need	

## Schedule C

### CHOC/CCMH FAP Extended Payment Plan Form

<b>Date:</b>	<b>DOS:</b>
<b>Patient Name:</b>	<b>ADJ Date:</b>
<b>Monthly Income: \$</b>	
<b>Subtract Essential Living Expenses:</b>	
<b>Rent/House Payment</b>	<b>\$</b>
<b>Maintenance</b>	<b>\$</b>
<b>Food</b>	<b>\$</b>
<b>Household Supplies</b>	<b>\$</b>
<b>Utilities</b>	<b>\$</b>
<b>Clothing</b>	<b>\$</b>
<b>Medical payments</b>	<b>\$</b>
<b>Insurance</b>	<b>\$</b>
<b>School/Child Care</b>	<b>\$</b>
<b>Child/Spousal Support</b>	<b>\$</b>
<b>Transportation</b>	<b>\$</b>
<b>Auto Exp/Gas/Repairs/Ins</b>	<b>\$</b>
<b>Car Payment</b>	<b>\$</b>
<b>Laundry/Cleaning</b>	<b>\$</b>
<b>Total Expenses</b>	<b>\$</b>

**Total Income after living expenses** \$ \_\_\_\_\_

**Extended Payment Plan, Monthly Payment** \$ \_\_\_\_\_