

PATIENT RIGHTS- MANAGEMENT

PURPOSE

To demonstrate ways Mason General Hospital & Family of Clinics (MGH&FC) respects, protects, and promotes the rights of the patient during their encounters.

POLICY

MGH&FC entities and staff members show their support of patient rights through interactions with patients and by involving them in decisions about their care, treatment, and services. This support includes, but is not limited to:

IDENTIFICATION OF AND INFORMING PATIENTS OF THEIR RIGHTS AND RESPONSIBILITIES (Joint Commission Standard RI.01.01.01)

- MGH&FC has developed and posted "Patient Rights and Responsibilities" in compliance with The Joint Commission recommendation, as well as the Centers for Medicaid and Medicare Services, outlining a list of rights and responsibilities.
- Patients are given the opportunity to have a printed copy of the "Patient Rights and Responsibilities" if they desire. A copy of this document is offered at time of admission, and is available on request at any time during the patient stay.
- There are written policies on procedures for specific patient rights, including but not limited to: visitation rights, right to privacy, right to pain management, access to health information, and prohibition to discrimination.
- "Patient Rights and Responsibilities" copies are available to staff to review relevant areas with patients, surrogates, and visitors as appropriate.

RIGHT TO EFFECTIVE COMMUNICATION (Joint Commission Standard RI.01.01.03)

- Information and education is provided in multiple modes tailored to patient age, language, learning preferences.
- Interpreter services are available 24/7 for many languages, including those most frequently encountered in the community. ([hyperlink - policies](#)) [hyperlink to information](#)

PATIENT RIGHTS- MANAGEMENT

- Provisions are made for learning barriers and impairments, such as for vision and hearing deficits.

RIGHT TO PARTICIPATE IN CARE DECISIONS (Joint Commission Standard Ri.01.02.01)

- Information about treatment, outcomes, services, and plan of care is provided at multiple points during the patient stay, from their Licensed Independent Practitioner and the MGH&FC staff; this includes involvement of the patient for preferences, educational activities, decision making, and the right to refuse care.

RIGHT TO INFORMED CONSENT (Joint Commission Standard RI.01.03.01, RI.01.03.03)

- There are written policies in place for informed consent and refusal

RIGHT TO KNOW CARE PROVIDERS (Joint Commission Standard RI.01.04.01)

- Provider information will be provided upon request.

RIGHT TO PARTICIPATE IN END-OF-LIFE DECISIONS (Joint Commission Standard RI.05.01)

- There are written policies for end-of-life care and surrogacy (Advance Directives)
- Palliative care orders are obtained and implemented as desired by patients or their surrogates.

PERSONAL RIGHTS (Joint Commission Standards (Ri.01.06.03, RI.01.06.05, R.I.01.07.01, RI.01.07.03)

- There are written policies regarding the right to be free from neglect and/or abuse, and for investigation of any complaints of neglect and/or abuse.
- Private telephone and mail services are available for all patients.
- Contact information is provided for MGH&FC Compliance Officer and Privacy Officer as well as the Department of Health Hotline. Advocacy and support contacts are provided on request; these referral numbers are maintained by the Patient Resources Department.
- There are written policies regarding complaint management.

PATIENT RIGHTS- MANAGEMENT

REFERENCES:

Rights and Responsibilities of the Individual (2012). The Joint Commission. Found at: <https://edition.jcrinc.com/Chapters.aspx?C=53>

Relevant and supportive policies and procedures found in hyperlinks in this document, with additional references contained within.

ADVANCE DIRECTIVE POLICY AND PROCEDURE

DEFINITIONS

Advance Directive- A written instruction, such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when the individual is incapacitated. The document expresses wishes about treatment preferences and the designation of a surrogate if the patient is incapacitated. Mason General Hospital and Family of Clinics use the 5 Wishes Model.

Durable Power of Attorney/Durable Power of Attorney for Health Care (abbreviated below as "DPOA") - A document that designates an agent or proxy to make Health care decision if the patient is no longer able to make them. The document directs the surrogate to function as "attorney-in-fact" and make decisions regarding all treatment, including the final decision about cessation of treatment.

Health Care Directive (abbreviated below as "Directive")- Term referring to Advance Directive or subset of Advance Directive, e.g. Mental Health Care Directive, Behavioral Health Care Directive, Durable Power of Attorney, POLST, etc.

Physician Order for Life Sustaining Treatment (abbreviated below as "POLST")- Document used to communicate decisions about the types(s) of life-sustaining treatment a patient desires that is signed by a licensed independent medical practitioner. Similar to an Advance Directive, but has more authority as a physician order that healthcare workers must follow.

POLICY

Mason General Hospital and Family of Clinics respects the rights of patients and, recognizes that each patient is an individual with unique health care needs. Because of the importance of respecting each patient's personal dignity, Mason General Hospital and Family of Clinics provides considerate, respectful care focused upon the patient's individual needs.

Mason General Hospital and Family of Clinics affirms the patient's right to make decisions regarding his/her medical care, including the decision to discontinue treatment, to the extent permitted by law.

ADVANCE DIRECTIVE POLICY AND PROCEDURE

The care of the dying patient is provided to optimize the comfort and dignity of the patient by:

- Treating primary and secondary symptoms that respond to treatment as desired by the patient or surrogate decision-maker and effectively managing pain.
- Acknowledging the psychosocial and spiritual concerns of the patient and the family regarding the dying and the expression of grief by the patient and family.
- By promoting the right of the patient, in collaboration with his/her physician, to make decisions involving his/her health care, including: The right of the patient to formulate Directives (verbal and written) and appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law.

Mason General Hospital and Family of Clinics has in place a mechanism to ascertain the existence of/or provide information about Directives at the time of presentation:

- This applies to all adults, 18 years or older that present as an inpatient, short stay/observation or a therapeutic outpatient.
- By providing the patient with written information and verbal communication of these rights at the time of admission.
- The provision of care is not conditioned on the existence of an Directive.
- If on file, the most recent Directive(s) is kept in the patient's medical record.
- The Directive(s) can be changed at any time while the person is competent to do so and the file will be updated.
- It is the responsibility of the patient's legal decision maker to exercise the rights delineated on behalf of the patient, if the patient has been judged incompetent in accordance with the law or is found by his/her physician to be medically incapable of

ADVANCE DIRECTIVE POLICY AND PROCEDURE

understanding the proposed treatment or procedure, or is unable to communicate his/her wishes regarding treatment.

On advice of the legal counsel of Mason General Hospital and Family of Clinics it shall be noted that, according to the law,

HOSPITAL AND CLINIC STAFF AND HOSPITAL AND CLINIC NOTARIES ARE NOT ABLE TO WITNESS, NOR FACILITATE IN, THE PREPARATION OF A LIVING WILL, ADVANCE DIRECTIVE, POWER OF ATTORNEY DESIGNATION, OR OTHER HEALTHCARE DIRECTIVE TO THE PHYSICIAN.

PROCEDURE

REGISTRATION RESPONSIBILITIES:

When an adult, 18 years or older presents for, registration to the hospital, the Central Registration staff will ascertain whether there is an Directive on file in the Medical Record. This can be accomplished by:

- Asking the patient or surrogate to respond by a "YES or NO" to the Advance Directive questions and indicating this, in the computer system which will result in printing this on the Face Sheet.

HEALTH INFORMATION MANAGEMENT RESPONSIBILITIES:

- At the time of an adult admission to the hospital, the Health Information Management Staff will accomplish the following:
 - a) Retrieve the patient's previous medical records and deliver them to the appropriate area.

ADVANCE DIRECTIVE POLICY AND PROCEDURE

- b) The medical record folder will contain any previous "Advance Directive, Living Will, Durable Power of Attorney, POLST, Directive to the Physician or Mental Health Directive".
- c) A sticker will be attached to the front of the medical record folder if there is an Advance Directive, Living Will, Durable Power of Attorney, POLST, Directive to the Physician or Mental Health Directive enclosed.
- The Health Information Management Department will be responsible for maintaining all Directives received at Mason General Hospital and Family of Clinics in the patient's medical record folder. The document(s) will be stored on the left hand side of the folder and will always be the top page.
- When a patient is discharged, any current Directives in the patient chart will be removed and placed in the Permanent Medical Record File Folder.
- Scanned versions of current Directives are available in the Electronic Medical Record.

NURSING STAFF AND/OR UNIT SECRETARY RESPONSIBILITIES:

- On admission, the Clinical Staff will review the old folder for a large green sticker indicating "Advance Directive, Living Will, Durable Power of Attorney, POLST, Directive to the Physician or Mental Health Directive On File" and the patients Face Sheet for the information from Central Registration. Note: The POLST must be an original document, not a copy.
- If the permanent chart has a (green) sticker, the Clinical Staff will place a green sticker stating "Advance Directive, Living Will, Durable Power of Attorney, POLST, Directive to the Physician or Mental Health Directive" on the "new" chart.
- If the face sheet "only" says there is an advance directive, s/he will ascertain whether a copy of the Directive(s) is present in the new chart and add the sticker to the outside of the new chart. (See below for actions if Directive copies are not found).
- If there is no sticker and the face sheet does not indicate an advance directive on file, a Unit Clerk does nothing and Nursing follows Nursing Admission History Assessment. .

ADVANCE DIRECTIVE POLICY AND PROCEDURE

- All charts will be maintained at the appropriate nursing unit.

At the time of the Nursing Admission History Assessment, the following information will be ascertained;

- Verification that the Advance Directive, Living Will, Mental Health Directive Durable Power of Attorney and/or other Directives on file is/are current. If current, note in Nursing Admission History Assessment.
- If the patient or surrogate state there is a document, but it is not in the medical record folder, direct the patient or surrogate to obtain this document for our file.
- When provided, update current chart with document and place a green sticker on the outside of the chart folder.
- Answer any questions, provide the brochure and/or make appropriate referrals for further information to the Patient Resources Department.
- If a referral needs to be made to the Patient Resources Department, this will be done by as soon as possible. **If this department is unavailable, the House Supervisor will provide this service.**
- Nursing staff shall utilize the Code Clarification Form and/or Physician Order for Life-Sustaining Treatment (POLST) Form to document a "Verbal Advance Directive". The RN will fill out the first half of the form and the physicians will fill out the rest of the order and sign it.
- At discharge, **original** version of the POLST will be returned to the patient or their surrogate; a copy is maintained in the medical record sent to HIM.

PATIENT RESOURCES RESPONSIBILITIES:

- When requested by the Nursing Staff, the Patient Resources Department will continue to answer any questions to the best of their ability and provide additional resources as needed.

Family of Clinics:

ADVANCE DIRECTIVE POLICY AND PROCEDURE

- Mason General Hospital-owned clinics will be encouraged to ask and obtain a copy of the patient's Directives, for those patients over the age of 18 who have such Directives.
- The Clinics owned by Mason County Public Hospital District will provide written educational materials to any patient asking for more information related Directives
- If a patient is in one of the Clinic settings, and experiences a cardiac arrest, an attempt to rescue the patient will be initiated and 911 will be called.

ADMINISTRATION RESPONSIBILITIES:

- Assure that the above-mentioned procedures are followed by the employed staff of the facility.
- Provide the opportunity for staff education; and community education in conjunction with other area health care organizations.
- Provide written material on Advance Directives, DPOA, and POLST.
- The Materials Department will be responsible for maintaining brochures and blank forms related to health care directives for other Departments to order.

Referenced Documents:

TJC Standard RI.01.05.01

Medicare and Medicaid Conditions of Participation. (Current manuals maintained in HIM)

Washington End of Life Consensus Coalition. Found at: www.wsma.or/about_wsma/weolcc.cfm

Advance Directives and other End of Life Documents. Washington State Medical Association.
Found at: www.wsma.org/patient_resources/endo-of-life.cfm

Relevant Revised Codes of Washington:

RCW 70.122- Living Will

RCW 70.32- Mental Health Advance Directives

RCW 70.245- Death with Dignity Act

RCW 11.94- Power of Attorney

Federal Patient Self-Determination Act- 42 CFR Part- 417

CHARITY CARE POLICY FOR THE UNINSURED & UNDERINSURED

PURPOSE

Mason General Hospital and Family of Clinics (the "District") is committed to the provision of emergency health care services to all persons in need of medical attention regardless of ability to pay. In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of charity care, consistent with the requirements of Washington Administrative Code 246-453, are established. These criteria's will assist staff in making consistent and objective decisions regarding eligibility for charity care while ensuring the maintenance of a sound financial basis.

The written policy includes: (a) eligibility criteria for charity care, (b) describes the basis for calculating amounts charged to patients eligible for charity care (c) describes the method by which patients may apply for charity care and (d) describes how the District will publicize the policy with the community serviced by the District.

POLICY

Financial assistance may cover all appropriate hospital-based medical services, received in the hospital inpatient or outpatient/clinic setting. Services not qualifying under financial assistance may include transportation costs, elective procedures, or separately billable professional services provided by the hospital's medical staff. Non-residents of Washington State are eligible for Financial Assistance consistent with Washington Administrative Code 246-453-060, which includes emergent, non-scheduled services only.

ELIGIBILITY CRITERIA

Charity care is generally secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare, Medicaid or medical assistance programs, other state, federal, or military programs, third party liability situations (e.g. auto accidents or personal injuries), or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.

The medically indigent patient will be granted charity care regardless of race, color, sex, religion, age, national origin, or immigration status.

In those situations where appropriate primary payment sources are not available, patients shall be considered for charity care under this District policy based on the following criteria consistent with requirements of WAC 246-453-040 and WAC 246-453-050:

CHARITY CARE POLICY FOR THE UNINSURED & UNDERINSURED

A. The full amount of hospital and/or clinic charges will be determined to be charity care for a patient whose gross family income is at or below 100% of the current federal poverty guidelines (consistent with Washington Administrative Code 261-14-027).

B. A sliding fee scale shall be used to determine the amount which shall be written off for patients with incomes between 101% and 400% of the current federal poverty level. All resources of the family as defined by the Washington Administrative Code 246-453 are considered in determining the applicability of the sliding fee scale in **Attachment A**.

CATASTROPHIC CHARITY CARE

The District may also write off as charity care amounts for patients with family income in excess of 400% of the federal poverty standards or at a higher percentage for those above 100% of the poverty guidelines, when circumstances indicate severe financial hardship or personal loss. This will be done only upon recommendation by the patient accounts representative or Director, Business Office with adequate justification and only upon approval by the Chief Financial Officer and the District's Board of Commissioners.

PROCESS FOR ELIGIBILITY DETERMINATION

Initial Determination

The District will make an initial determination of eligibility based on written application for charity care as outlined in **Attachment B**. Pending final eligibility determination, the District will not initiate collection efforts or requests deposits, provided that the responsible party is cooperative with the District's efforts to reach a determination of sponsorship status, including return of applications and adequate documentation.

The District shall use an application process for determining initial interest in and qualification for charity care. Should patients not choose to apply for charity care, they shall not be considered for charity care unless other circumstances become known to the District.

Final Determinations

Charity care forms, instructions, and written applications shall be furnished to patients when charity care is requested, when need is indicated, or when financial screening indicates potential need. Applications, whether initiated by the patient or the hospital and/or clinics should be accompanied by documentation to verify income amounts indicated on the application form. One or more of the following types of documentation may be acceptable for purpose of verifying income:

1. W-2 withholding statements for all employment during the relevant time period;

CHARITY CARE POLICY FOR THE UNINSURED & UNDERINSURED

2. Pay stubs from all employment during the relevant time period;
3. An income tax return from the most recently filed calendar year;
4. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance (denial for Medicaid purely on the basis of failure to apply timely will never be sufficient documentation by itself), if applicable;
5. Forms approving or denying unemployment compensation; or
6. Written statements from employers or welfare agencies. Patients will be asked to provide verification of ineligibility for Medicaid or Medical Assistance. During the initial request period, the District may pursue other sources of funding, including Medicaid.

Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. This process will be determined by the District and will take into consideration seasonal employment and temporary increases and/or decreases of income. Applications will be processed within 14 days of receipt of the application to the Business Office.

Charity Care will be granted based on the approval guidelines as outlined in **Attachment A**.

Income verification is required as outlined in **Attachment C**

For elective services not covered please contact the perspective clinic.

Approvals

Charity care applications will be approved once all required information is received and the income guidelines for granting charity care have been met. Applications will be processed within 14 days of receiving the application in the Business Office.

Eligibility on a completed and approved application is valid for eligible services received within the subsequent ninety (90) days from application approval date and will be retroactive for eligible services for all dates of service that the charity care is being granted. Approved charity care for eligible services rendered in a District clinic(s) will be valid within the subsequent 180 days from application approval date and retroactive to the dates of service for which charity is being granted.

Time Frame for Final Determination and Appeals

The District shall provide final determination within fourteen (14) days of receipt of all application and documentation material.

CHARITY CARE POLICY FOR THE UNINSURED & UNDERINSURED

Denials

Denials will be written and include instructions for appeal or reconsideration as follows. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income and family size to the Patient Accounts Representative within fourteen (14) days of receipt of notification. All appeals will be reviewed by the Patient Accounts Representative and the Director, Business Office.

If this determination affirms the previous denial of charity care, written notification will be sent to the patient/guarantor and the Department of Health in accordance with state law.

DOCUMENTATION AND RECORDS

- A. Confidentiality: All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.
- B. Documents pertaining to charity care shall be retained for five (5) years.

PROCESS FOR COMMUNICATION

The District's charity care policy shall be publicly available in the following ways:

- A. Financial agreement forms will state that financial responsibility is waived or reduced if the patient is determined eligible for charity care.
- B. Signage indicating the District's participation in a charity care program shall be openly posted in public areas of the Hospital and Clinics.
- C. The District will provide written notice of District's charity care policy to patients upon request.
- D. Both written information and verbal explanation shall be available in any language spoken by more than ten percent (10%) of the population in the District's service area. The District has identified Spanish language to be included in this context.

CHARITY CARE POLICY FOR THE UNINSURED & UNDERINSURED

ATTACHMENT A

Mason General Hospital & Family of Clinics Percentage of Sliding Fee Scale - 2013

Family Size	Federal Poverty Level ¹														
	100%		101% - 140%		141% - 180%		181% - 220%		221% - 260%		261% - 300%		301% - 340%		341% - 400%
1	\$11,490	\$11,490	\$16,086	\$16,086	\$ 20,682	\$20,682	\$ 25,278	\$25,278	\$ 29,874	\$ 29,874	\$ 34,470	\$ 34,470	\$ 39,066	\$ 39,066	\$ 45,960
2	\$15,510	\$15,510	\$21,714	\$21,714	\$ 27,918	\$27,918	\$ 34,122	\$34,122	\$ 40,326	\$ 40,326	\$ 46,530	\$ 46,530	\$ 52,734	\$ 52,734	\$ 62,040
3	\$19,530	\$19,530	\$27,342	\$27,342	\$ 35,154	\$35,154	\$ 42,966	\$42,966	\$ 50,778	\$ 50,778	\$ 58,590	\$ 58,590	\$ 66,402	\$ 66,402	\$ 78,120
4	\$23,550	\$23,550	\$32,970	\$32,970	\$ 42,390	\$42,390	\$ 51,810	\$51,810	\$ 61,230	\$ 61,230	\$ 70,650	\$ 70,650	\$ 80,070	\$ 80,070	\$ 94,200
5	\$27,570	\$27,570	\$38,598	\$38,598	\$ 49,626	\$49,626	\$ 60,654	\$60,654	\$ 71,682	\$ 71,682	\$ 82,710	\$ 82,710	\$ 93,738	\$ 93,738	\$110,280
6	\$31,590	\$31,590	\$44,226	\$44,226	\$ 56,862	\$56,862	\$ 69,498	\$69,498	\$ 82,134	\$ 82,134	\$ 94,770	\$ 94,770	\$107,406	\$107,406	\$126,360
7	\$35,610	\$35,610	\$49,854	\$49,854	\$ 64,098	\$64,098	\$ 78,342	\$78,342	\$ 92,586	\$ 92,586	\$106,830	\$106,830	\$121,074	\$121,074	\$142,440
8	\$39,630	\$39,630	\$55,482	\$55,482	\$ 71,334	\$71,334	\$ 87,186	\$87,186	\$103,038	\$103,038	\$118,890	\$118,890	\$134,742	\$134,742	\$158,520
Each Additional person	\$ 4,020	\$ 4,020	\$ 5,628	\$ 5,628	\$ 7,236	\$ 7,236	\$ 8,844	\$ 8,844	\$10,452	\$10,452	\$12,060	\$12,060	\$13,668	\$13,668	\$16,080
Discount	100%	90%		80%		70%		60%		50%		40%		30%	

⁽¹⁾ 2013 Federal Poverty Guidelines as published in the Federal Register for the 48 Contiguous States and the District of Columbia. These guidelines are used for calculating charity care eligibility under the

Revised Code of Washington (RCW) 70.170

CHARITY CARE POLICY FOR THE UNINSURED & UNDERINSURED

Attachment B

APPLICATION FOR DETERMINATION FOR ELIGIBILITY FOR UNCOMPENSATED CARE

MASON GENERAL HOSPITAL & FAMILY OF CLINICS

901 MT. VIEW DRIVE | PO Box 1668

SHELTON, WA 98584

360-427-9547

Please complete all items

Date of Request: _____

I hereby request that Mason General Hospital and Family of Clinics make a written determination of my eligibility for Uncompensated (Charity) Care services at Mason General Hospital & Family of Clinics. I understand that the information which I submit concerning my annual income and family size is subject to verification. I also understand that if the information I submit is determined to be false, such a determination will result in a denial of uncompensated services and that I will be liable for charges for services provided.

1. NAME: _____
 First Middle Last

2. PHONE: _____

3. ADDRESS: _____
 PO Number/Street City State Zip Code

4. OCCUPATION _____ EMPLOYER _____

If unemployed, last date worked _____

5. EMPLOYER OF OTHER FAMILY MEMBERS _____

CHARITY CARE POLICY FOR THE UNINSURED & UNDERINSURED

6. INCOME* TOTAL FAMILY INCOME RECEIVED FOR THE LAST 3 MONTHS _____
 Has there been other employment in the past 6 months? _____

*Income is the total cash receipts before taxes from all sources including the patient's income and income of other family members living in the same household to include such things as wages, farm or self-employed income, public assistance, social security, unemployment compensation, alimony, child support, pensions, and other.

VERIFICATION OF INCOME

Verification of income is required for determination of eligibility of Charity Care as outlined in attachment _____

Please indicate which of the following you are attaching to this application.

Pay check stubs _____ Income Tax Form _____ Other _____

IF NO INCOME, an explanation of the circumstances for no income must be made below on how you are living on zero income

7. LIST FAMILY MEMBERS-Dependents (legal custody)

Name	Relationship	Age

CHARITY CARE POLICY FOR THE UNINSURED & UNDERINSURED

8. PATIENT CARE SERVICES INFORMATION (What services do you want considered?)

Prior Medical Service? Date(s) of service _____

List Patients who received service(s):

Medical Service not yet rendered? Type of Service(s) _____

Date(s) of service _____

List Patients who received service(s):

Have you received care at any of the following clinics listed below:

- | | |
|------------------------------------|-----------|
| Oakland Bay Pediatrics _____ | Yes or No |
| MGH Eye Clinic _____ | Yes or No |
| MGH Shelton Orthopedics _____ | Yes or No |
| MGH Surgery Clinic _____ | Yes or No |
| Shelton Family Medicine _____ | Yes or No |
| Mountain View Women's Clinic _____ | Yes or No |
| MGH Family Health Clinic _____ | Yes or No |
| MGH Ankle and Foot Clinic _____ | Yes or No |

CHARITY CARE POLICY FOR THE UNINSURED & UNDERINSURED

I/WE HEREBY AUTHORIZE Mason General Hospital & Family of Clinics to verify the above information including employment history and to check the information on file at the credit bureau(s) or any other source named in the application. I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Washington Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges, and I will take any reasonable action necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that Mason General Hospital & Family of Clinics can judge my eligibility for Uncompensated Care Services based on the established criteria on file. If any information I have given proves to be untrue, I understand that Mason General Hospital and Family of Clinics may re-evaluate my financial state and take whatever action becomes appropriate.

Applicant's Signature _____ Date of Request _____

CHARITY CARE POLICY FOR THE UNINSURED & UNDERINSURED

Attachment C

Applying for Financial Assistance

When completing an application for financial assistance, following the steps below will help expedite processing:

1. Please fill out the application completely.
2. Attach income verification documents to the application and mail to:

Mason General Hospital & Family of Clinics
PO Box 1668
Shelton, WA 98584

Or fax to: 360-427-9597

All complete Applications are processed within 14 business days of receipt and must include income verification documentation. Examples of income verification documents include:

- Payroll statements with your gross income for the past three months, including unemployment compensation.
- Payroll statements with gross income for your spouse for past three months, including unemployment compensation.
- Social Security income statements.
- A profit and loss statement if you are self-employed.
- Documents verifying Child Support payments.
- Proof of pension and retirement information, if applicable.

If you have little or no income, DSHS letter is required along with 2 letters stating how you are getting by without an income, one from patient, one from person who is helping patient.

If you have further questions about applying for financial assistance, please call Patients Accounts @ 360-427-3601.