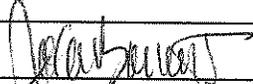


**CASCADE VALLEY HOSPITAL AND CLINICS  
POLICY**

NUMBER: 03-3-004		DATE EFFECTIVE: 4/91	
TITLE: Charity Care	APPROVAL SIGNATURE:		
	REVIEW DATE	REVISE DATE	SIGNATURE
DIVISION: CVHC	10/12	10/12	
DEPARTMENT: Universal Patient Care	02/13	02/13	
ROUTE TO: Registration, Patient Financial Services, CFO	7/13	7/13	
	12/13	12/13	
CROSS REFERENCE: BOC Approved 12/2013;   DOH Approved 12/2013, WAC 246-453-020	3/14	3/14	
	9/14	9/14	

**SCOPE** This policy applies to all employees whose terms and conditions of employment are administered by Cascade Valley Hospital and Clinics and is effective for dates of service after 2/19/04.

**POLICY** To provide medically necessary health care to all patients regardless of ability to pay. The District shall grant Charity Care to all eligible hospital patients regardless of race, color, sex, religion, age, or national origin. Financial assistance and charity care shall be limited to "appropriate hospital-based medical services" as defined in WAC246-453-010(7) for those patients residing in the hospital's designated service area. The service area is defined as those boundaries congruent with the Public Hospital District, which includes all residents with zip codes 98223, 98241, 98252, 98259, 98271, 98287 and 98292. Non-residents of the defined service area are eligible for financial assistance consistent with WAC 246-453-060 for emergent services only. Financial assistance for uninsured non residents of the service area for any non-emergent service is limited to the uninsured discount defined in this policy/procedure. The staff shall offer assistance to all patients in identifying their eligibility for charity care. The provisions of this policy/procedure do not apply to the professional services of the hospital's medical staff or to Cascade Valley Arlington Surgery Center.

**DESCRIPTION OF ELIGIBILITY CRITERIA**

Charity Care is 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. When patient financial balances are considered appropriate for charity care following primary insurance coverage payments and a complete application, financial assistance eligibility will ultimately be determined by type of service (emergent or non-emergent) and by service area, in the same manner as when charity would be considered the only form of payment.

In those situations where appropriate primary payment sources are not available, patients shall be considered for Charity Care under this policy based on the following criteria as calculated by annualizing the patient's income at the time services were rendered, less any loss of benefits or sources of incomes (e.g., loss of worker's compensation or unemployment benefits). Adjustments may be considered for recent changes in income of the most recent ninety (90) days, if the changes result in a significant variation in financial circumstance.

- A. Charity Care is available for any patient whose gross family income is at or below 200% of the current federal poverty guidelines.
- B. Catastrophic Charity. The hospital may write off as charity care amounts for patients with family income in excess of 200% of the federal poverty guidelines when circumstances indicate severe financial hardship or personal loss.
- C. Available assets may be used to determine eligibility for Charity Care if the family income is greater than 100% of the federal guidelines. Assets must be easily accessible or available to become accessible. Examples of assets which may be accessed before charity care is received include, but are not limited to: trust funds, cash value life insurance, pension funds, individual retirement accounts, savings accounts, certificates of deposit, retirement accounts, stocks, bonds, and money market accounts. The first \$2,000 in assets will not be considered.
- D. CVHC will follow a sliding scale in considering income and assets for charity care.

<u>Family Income</u>	<u>Amount of Bill Written Off To Charity Care</u>
0 – 100% of FPG	100%
101 – 133% of FPG	75% based solely on income. Remaining 25% to be paid by patient's/guarantor's assets, if existent. If patient/guarantor has no assets, or insufficient assets to cover the debt, CVHC will grant charity care for the remaining billed amount to covered by assets. The first \$2,000 of assets will not be considered.
134 – 166% of FPG	62% based solely on income. Remaining 38% to be paid by patient/guarantor's assets. If patient/guarantor has no assets, or insufficient assets to cover the debt, CVHC will grant charity care for the remaining billed amount not covered by assets. The first \$2,000 of assets will not be considered.
167 – 200% of FPG	48% based solely on income. Remaining 52% to be paid to be paid by patient/guarantor's assets. If patient/guarantor has no assets, or insufficient assets to cover the debt, CVHC will grant charity care for the remaining billed amount not covered by assets. The first \$2,000 of assets will not be considered.
201% and up of FPG	Any patient who has no insurance may qualify for an uninsured discount of 32%. An application is required but supporting income and asset documentation is not required. Non-Foreign residents are not eligible for the uninsured discount.

PROCESS FOR ELIGIBILITY DETERMINATION

- A. Process for Eligibility Determination:

1. Initial Determination: After the patient registration process, the Financial Counselor will make an initial determination of eligibility based on verbal or written application for Charity Care after contact by the patient or his/her representative. Pending final eligibility determination, CVH will not initiate collection efforts provided that the responsible party is cooperative with our efforts to reach a determination of sponsorship status, including return of applications and documentation within ||fourteen (14) days of receipt, or such time as the person's medical condition may ||require, or such time as may reasonably be necessary to secure and to present ||documentation. The failure of a responsible party to reasonably complete appropriate application procedures shall be sufficient for the hospital to initiate collection efforts directed at the patient/guarantor.
2. CVH 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 or intent become known to the District.
3. Requests to provide Charity Care will be accepted from sources such as physician, community or religious groups, social services, financial services personnel, or the patient. If the District becomes aware of factors which might qualify the patient for Charity Care under this policy, it shall advise him or her of this potential and make an initial determination that such account is to be treated as Charity Care.
4. Charity Care forms, instructions, and applications shall be furnished to patients when Charity Care is requested, when need is indicated, or when financial screening indicates potential need. All applications, whether initiated by the patient or the District, should be accompanied by documentation to verify income amounts and assets indicated on the application form. One or more of the following types of documentation may be acceptable to base the final determination of charity care sponsorship status, when the income information is annualized as may be appropriate:
  - a. W-2 withholding statements for all employment during the relevant time period.
  - b. Pay stubs from all employment during the relevant time period.
  - c. An income tax return from the most recently-filed tax year.
  - d. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance.
  - e. Forms approving or denying unemployment compensation.
  - f. Written statements from employers or welfare agencies.||Administrative discretion regarding exact income level may be used in cases where ||the responsible party is unable to provide documentation as indicated in this section.  
\* ||Examples may include when the responsible party's identification as an indigent ||person is obvious to hospital personnel and the hospital is able to establish the ||position of the income level within the sliding fee schedule set by the hospital. In ||these exceptions, hospital may rely on written and signed statements from the ||responsible party in order to make a final determination of eligibility for ||classification as an indigent person.
5. Patients will be asked to provide verification of ineligibility for Medicaid or Medical Assistance. During the initial request period, the Hospital may pursue other sources of funding, including Medicaid. Patients are strongly encouraged to pursue eligibility for health insurance coverage through the Washington State Health Plan Finder. The Patient advocate will assist those patients who would qualify under the new health benefit exchange criteria based on income and household size, to gain coverage under Washington Apple Health, prior to approving charity.
6. Income shall be annualized from the date of service based upon documentation provided and upon verbal information provided by the patient. For the purposes of determining the most accurate and fairly represented monthly average of qualifying income, annual income shall be calculated based on one or more of the following:

- a. most recent tax return,
  - b. the last twelvemonths of actual income, or
  - c. annualized based on the last ninety (90) days prior to the date of service for which charity is being requested in the event that a significant change has occurred in the guarantor's income.
7. CVH will accept a written statement of no employment, no assets and/or no income if the patient has no other proof of income.
8. Final Determinations: Time Frame for Final Determination and Appeals: - the District shall provide final determination within 14 days of receiving all required application and documentation material. All decisions will be documented accordingly in the respective account(s).
9. ||Approvals: Charity care determinations can be reached at any time upon learning of ||facts or receiving documentation that qualifies a patient for charity care.
- a. ||If the patient has made any payments against the account, any payments made in ||excess of the amount determined to be appropriate in accordance with WAC ||246-453-040 will be refunded within 30 days of making the determination to ||grant charity care.
  - b. The account will be written off to the Charity Journal.
  - c. Patients having dates of service within 30 days of determination will be automatically determined Charity for that Date of Service.
10. ||Denials: All responsible parties denied charity care sponsorship under WAC 246-||453-040 (1) or (2) shall be provided with, and notified of, an appeals procedure that ||enables them to correct any deficiencies in documentation or request review of the ||denial and results in review of the determination by the hospital's CFO or Assistant ||Administrator. Denials will be written and include the basis for denial and ||instructions for appeal or reconsideration as follows:
- a. The patient /guarantor may appeal the determination of eligibility for Charity Care by providing additional verification of income or family size to the Assistant Administrator within thirty (30) days of receipt of initial notification. During the first 14 days of this period, the hospital will not refer the account issue to an external collection agency; however, after the first 14 days and no appeal has been filed, the hospital may initiate collection activities (WAC 246-453-050).
  - b. In the event that the hospital's final decision upon appeal affirms the previous denial of charity care designation, the responsible party and the Department of Health shall be notified in writing of this decision and the basis of the decision and the Department of Health shall be provided with copies of documentation upon which the decision was based.
  - c. Alternative payment methods will be offered the patient if the denial is affirmed unless the Account has been in a self-pay status in excess of 90 days.
11. The Federal Poverty Guideline reflects updates yearly. See attached for current year's guidelines.
12. ||Accounts previously assigned to an external agency will be placed on hold after ||hospital discovers that an appeal has been filed, and will remain on hold during the ||final determination process until the appeal is finalized. If charity is granted for accounts assigned to an agency, principle balances will be reduced or cancelled accordingly. In the case of a denied charity decision, the responsible party will have the right to appeal the decision under section 9(a) of this policy/procedure.
13. If a responsible party is subsequently found to have met the charity care criteria at the time the services were rendered, any payments in excess of the amount determined to be appropriate in accordance with WAC 246-453-040 shall be refunded to the patient within 30 of achieving charity care designation.

**DOCUMENTATION AND RECORDS**

- A. Confidentiality of the patient/guarantor application shall be kept at all times. The support information will be kept with the application in the Patient Advocate's office.
- B. All documentation pertaining to the application for Charity Care will be retained for six (6) years.

**NOTIFICATION**

The District's Charity Care Policy shall be publicly available through the posting of a sign, and notification in the Admission Consent Form. The Admission Process will initiate the process and the Patient Accounts will encourage patients to apply where the initial information identifies the patient/guarantor of eligibility.

**2014 Poverty Guidelines for the 48 Contiguous States and the District of Columbia**

Household Size	100%	133%	150%	200%
1	\$11,490	\$15,282	\$17,235	\$22,980
2	\$15,510	\$20,628	\$23,265	\$31,020
3	\$19,530	\$25,975	\$29,295	\$39,060
4	\$23,550	\$31,322	\$35,325	\$47,100
5	\$27,570	\$36,668	\$41,355	\$55,140
6	\$31,590	\$42,015	\$47,385	\$63,180
7	\$35,610	\$47,361	\$53,415	\$71,220
8	\$39,630	\$52,708	\$59,445	\$79,260
For each additional person, add	\$4,020	\$5,347	\$6,030	\$8,040

**2013 Poverty Guidelines for the contiguous States and the District of Columbia**

Household Size	100%	133%	150%	200%
1	\$11,490	\$15,282	\$17,235	\$22,980
2	\$15,510	\$20,628	\$23,265	\$31,020
3	\$19,530	\$25,975	\$29,295	\$39,060
4	\$23,550	\$31,322	\$35,325	\$47,100
5	\$27,570	\$36,668	\$41,355	\$55,140
6	\$31,590	\$42,015	\$47,385	\$63,180
7	\$35,610	\$47,361	\$53,415	\$71,220
8	\$39,630	\$52,708	\$59,445	\$79,260
For each additional person, add	\$4,020	\$5,347	\$6,030	\$8,040

<http://aspe.hhs.gov/povety/12poverty.shtml>