Othello Community Hospital Othello, Washington		Policy Number BP 18	Total Pages 6
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Approvals _____ _____ _____ _____		Policy/Procedure	
		Originating Department: Financial Services	

Purpose:

To help low income people and families pay for hospital medical services. Financial assistance is either free care or reduced-price care, depending on income.

Policy/Procedure:

The attached policy/procedure describes Othello Community Hospital's financial assistance program.

OTHELLO COMMUNITY HOSPITAL
FINANCIAL ASSISTANCE POLICY

Effective October 24, 2014

Mission

Othello Community Hospital (OCH) is committed to the provision of 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 requirement of WAC 246-453-20, 246-453-030, 246-453-040 and 246-453-050 and the voluntary effort of the Washington State Hospital Association are established. These criteria will assist staff in making consistent and objective decisions regarding eligibility for financial assistance while ensuring the maintenance of a sound financial base. Charity care and/or financial assistance refer to free or reduced prices for care based on income.

Charity care and/or financial assistance will be granted regardless of race, color, sex, religion, age, national origin, creed, marital status, physical or mental disability, sexual orientation, and veteran status.

Categories of Charity Care

Charity care is available to two categories of patients: 1) those patients for whom it 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 (herein referred to as "Insured Patients") and 2) those patients for whom no other financial resources are available (herein referred to as "Uninsured Patients").

Eligibility for Charity Care

1. Initial Determination: During the patient registration process, the hospital will make an initial determination of eligibility based on verbal or written application for charity care. Pending final eligibility determination, the hospital will not initiate collection efforts or request for deposits, provided that the responsible party is cooperative with the hospital's efforts to reach a determination of sponsorship status, including return of applications and documentation within fourteen (14) days of receipt. Additional time may be allowed for the return of applications and documentation in consideration of special circumstances, such as medical condition and/or difficulty obtaining documentation.

   The hospital shall use an application process for determining initial interest in and qualification for charity care. 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 hospital 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.

2. Final Determination:

   a. Prima Facie Write-Offs. The hospital may choose to grant charity care based solely on the initial determination. In such cases, the hospital will not complete full verification or documentation of any request.

   b. 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. All applications, whether initiated by the patient or the hospital, should be accompanied by documentation to verify income amounts indicated on the application form. Patients shall be considered for charity care under this hospital policy based on the following criteria as calculated for the 12 months prior to the day of request. One or more of the following types of documentation may be acceptable for purposes of verifying income:

      - W-2 withholding statements for all employment during the relevant time period.
      - Pay stubs from all employment during the relevant time periods.
      - An income tax return from the period related to the date of the service provided. If a tax return is not available for the current period, one may be used from the previous year.
      - Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance.
      - Forms approving or denying unemployment compensation.
      - Written statements from employers or welfare agencies.

   c. During the initial period, the hospital may pursue other sources of funding, including Medicaid. If it appears that a patient is likely to qualify for Medicaid or Medical Assistance, then the patient will be asked to provide verification of ineligibility for Medicaid or Medical Assistance. Patients who are clearly ineligible (e.g., a single adult male) will not be required to prove their ineligibility.

   d. Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. The annualization process will be determined by the hospital and will take into consideration seasonal employment and temporary increases and/or decreases in income.

   e. Patients may apply for charity care on old accounts. The application and the financial information need to pertain to the year in which the service was provided. Determination of charity eligibility for old accounts will be based on Federal Poverty Guidelines for the year services were provided, and the charity

discount percentage for uninsured patients above 166% of the FPL will likewise be determined by the discount grid in effect at the time services were provided. If there are multiple accounts in multiple years, an application and financial information need to be provided for each year. If a single account has charges crossing two years, then eligibility and discount will be determined based on the year with the bulk of the charges, or on the earlier year if the charge amounts in each year are equal.

f. Income will be considered from all family members listed as living in household.

g. Available assets may be used to determine eligibility for charity care if family income is greater than 100% of the federal poverty level.

h. It is the patient's responsibility to complete the charity care application and to provide financial information when requested to do so by the hospital.

3. Time Frame for Final Determination and Appeals: The hospital shall provide final determination within fourteen (14) days receipt of all application and documentation material.

4. Denials: Denials will be written and include instructions for appeal or reconsideration. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income or family size to the Business Office Manager within thirty (30) days of receipt of notification. In the event an appeal is filed, any collection action previously initiated on the appellant accounts will be suspended pending reconsideration and final determination. All appeals will be reviewed by the Director of Finance and/or Administrator. 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.

5. Patient's Financial Obligation: The financial obligation of the patient/responsible party which remains after the application of this policy may be paid in monthly installments over a reasonable period of time, without interest or late fees, as negotiated between the hospital and the patient/responsible party. Patients may be sent to collection if they do not maintain their financial obligation.

6. Refunds: In the event that a patient or responsible party pays a portion or all of the charges on an account and is subsequently found to have met the charity care criteria at the time services were provided, any payments exceeding their financial obligation will be refunded within thirty days of the eligibility determination. This does not apply to accounts for which legal action has been initiated under the normal collection process.

Sliding Fee Scale for "Insured Patients"

The amount of hospital charges to be written off, related to the portion of the bill that is the patient's responsibility, will be determined to be charity care for any patient whose gross family income: 1) falls within the guidelines of the schedule shown below and 2) is the amount of gross family income earned during the year in which patient care was received.

Income as a Percentage of the Federal Poverty Level	Percentage Discount
Equal to or less than 100%	100%
101% to 133%	75%
134% to 166%	50%
167% to 200%	25%

Sliding Fee Scale for "Uninsured Patients"

In accordance with the voluntary effort of the Washington State Hospital Association, patients considered uninsured are eligible for discounts per the following methodology:

- No uninsured patient with income under 100 percent of the poverty level is required to pay for care. Uninsured means no third party insurance. Health savings accounts are considered insurance. Income for those under 100 percent of poverty includes both earned and unearned income, but excludes assets.

- No uninsured patient with income between 101 and 200 percent of the poverty level is required to pay more than the estimated cost of his/her care. Cost is the charge times the hospital's average cost-to-charge ratio, which is based on the hospital's previous year's Year End Report filed with the Washington State Department of Health. Income for those between 101 and 200 percent of the poverty level includes earned and unearned income, but also may include assets.

- No uninsured patient with income between 201 and 300 percent of the poverty level is required to pay more than 130 percent of the estimated cost of his/her care. Cost is the charge times the hospital's average cost-to-charge ratio, which is based on the hospital's previous year's Year End Report filed with the Washington State Department of Health.

The amount of hospital charges to be written off, related to the portion of the bill that is the patient's responsibility, will be determined to be charity care for any patient whose gross family income: 1) fall within the guidelines of the schedule shown below and 2) is the amount of gross family income earned during the year in which patient care was received.

Income as a Percentage of the Federal Poverty Level	Percentage Discount
Equal to or less than 100%	100%
101% to 133%	*75%*
134% to 166%	*50%*
167% to 200%	*49%*
201% to 300%	*34%*

Severe Hardships

The hospital may also write off as charity care amounts for patients with family income in excess of 200 percent of the federal poverty standard for the insured and 300 percent for the uninsured when circumstances indicate severe financial hardship or personal loss.

Notification

OCH will provide written notice to all patients informing them about the availability of financial assistance. OCH will post signs publicizing the availability of financial assistance in English and Spanish. This policy will also be made available in English and Spanish to those so requesting.

Collection Practices

The OCH Board of Commissioners will receive an annual summary report on collection actions taken.

With respect to the turning over of accounts to collection, the following will occur on a monthly basis: 1) the hospital's business office manager will submit a list of accounts to the CFO and/or CEO for review and/or modification, 2) the CFO and/or CEO will then submit the list of accounts to the Finance Committee for review and/or modification, 3) the Finance Committee will submit a summary report to the Board, and 4) the Board will render decision.

With respect to the filing of liens on primary residences, the following will occur: 1) the hospital's collection agency will first submit a recommendation to the CFO and/or CEO for review and/or modification, 2) the CFO and/or CEO will then submit a recommendation to the Finance Committee for review and/or modification, 3) the Finance Committee will submit a recommendation to the Board for review and/or modification, and 4) the full Board will render a final decision.

Confidentiality, Documentation, and Records

All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.

Documents pertaining to charity care shall be retained for seven (7) years.