POLICY:
Highline MedicalCenter ("Highline") is committed to providing appropriate urgent/emergent medical attention to all persons regardless of ability to pay. Highline is further committed to the provision of appropriate hospital-based medical services on a discounted basis to Indigent Persons, Medically Indigent Persons, and Uninsured Persons of Limited Means ("Charity Care"). In order to fulfill its commitment to provide Charity Care, Highline, in accordance with the requirements of RCW 70.170 and WAC 246-453, provides no charge and sliding scale discounted services to Indigent Persons. The federal poverty guidelines assist Highline Staff in making consistent and objective decisions regarding eligibility for Charity Care. In addition, Highline may provide Charity Care to all persons with insufficient income to enable them to pay for care or cost-sharing amounts.

DEFINITIONS:
"Indigent Persons" means those patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 400% of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payor;

"Responsible Party" means the individual who is responsible for the payment of any hospital charges which are not covered by a third-party payor.

ELIGIBILITY CRITERIA:
Eligibility determinations regarding Charity Care and decisions regarding collection of amounts owed to Highline by Responsible Parties shall be made in accordance with this Policy and the Highline Charity Care Policy Procedures. Highline will not impose unreasonably burdensome application procedures for Charity Care eligibility upon the Responsible Party, and will take into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the Responsible Party's capability of complying with the application procedures. Highline must make every reasonable effort to determine the existence or nonexistence of any available third-party coverage that might cover in full or in part the charges for services provided to each patient.

Highline may deny Charity Care to any person who is uncooperative with Highline in the Charity Care eligibility determination process. Responsible Parties will be considered for Charity Care on the following basis:

A. All Responsible Parties with family income equal to or below two hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be Indigent Persons qualifying for Charity Care for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party coverage; and
B. Responsible Parties with family income between two hundred one and four hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be Indigent Persons qualifying for discounts from charges related to appropriate hospital-based medical services in accordance with Highline's Sliding Fee Schedule (Exhibit A), and such additional amounts as Highline may determine in its sole discretion, depending on individual financial circumstances;

C. Highline, in its sole discretion, may classify any individual Responsible Party whose income exceeds four hundred percent of the federal poverty standard, as adjusted for family size, as an Indigent Person eligible for a discount from charges based upon that Responsible Party's individual financial circumstances, severe financial hardship or personal catastrophic loss.

Highline's Sliding Fee Schedule shall be updated annually in accordance with the federal poverty guidelines published in the Federal Register.

Responsible Parties receiving discounts under the Highline Charity Care Policy shall remit the balance of the discounted charges in accordance with Highline's ordinary billing and collection practices.

PROCESS FOR ELIGIBILITY DETERMINATION:
Highline's Charity Care Policy shall be posted or prominently displayed within public areas of the hospital, and shall be provided to the Responsible Party and explained at the time that Highline requests information with regard to the availability of any third-party coverage. The Policy will be displayed and explained in any language spoken by more than ten percent of the population in Highline's service area, and interpreted for other non-English speaking or limited English speaking or other patients who are unable to read or understand the written Policy or oral explanation. Highline will notify any Patient or any Responsible Party (consistent with HIPAA Privacy rules/regulations) who may be eligible for Charity Care. 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.

Responsible Parties may qualify for Charity Care at any time (pre-admission through collections) for any period of time as determined by Highline Medical Center. During the patient registration process, Highline will make an initial determination regarding Charity Care eligibility based on an oral or written application for Charity Care. The initial determination of Charity Care eligibility shall be made at the time of admission or as soon as possible following the initiation of services to the patient. Provided that the Responsible Party is cooperative, Highline will suspend all collection efforts and will not require any deposit pending an initial determination of Charity Care eligibility. During the pendency of Highline's initial or final determination of Charity Care eligibility, Highline may pursue reimbursement from any third-party coverage that may be identified to Highline.

For the purpose of reaching an initial determination of Charity Care eligibility, Highline shall rely upon information provided orally by the Responsible Party. Any Responsible Party who is initially determined to be Charity Care-eligible shall be provided with at least fourteen (14) calendar days or such time as the person's medical condition may require, or such time as may reasonably be necessary to secure and to present required documentation.

All applications must be accompanied by one or more of the following documentation to verify income amounts indicated on the application form:

1. A "W-2" withholding statement;
2. Pay stubs;
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;

5. Forms approving or denying unemployment compensation; or
6. Written statement from employers or welfare agencies;

In the event that the Responsible Party is not able to provide any of the documentation described above, Highline shall rely upon written and signed statements from the Responsible Party for making a final determination of eligibility for classification as an Indigent Person. Information requests, from Highline to the Responsible Party, for the verification of income and family size shall be limited to that which is reasonably necessary and readily available to substantiate the Responsible Party's qualification for Charity Care, and may not be used to discourage applications for Charity Care. Duplicate forms of verification shall not be demanded from the Responsible Party.

Highline may request such further financial statements or information should it consider extending Charity Care to Responsible Parties in excess of the amount indicated by the Sliding Fee Schedule. If identification as an Indigent Person is obvious to Highline personnel, and Highline is able to establish the position of the income level within the broad range of the federal poverty guidelines or Highline's Sliding Fee Schedule, Highline is not obligated to establish the exact income level or to request the documentation listed above from the responsible party, unless the patient or Responsible Party requests further review.

APPROVAL/DENIAL:
The failure of a Responsible Party to reasonably complete Highline's application procedures shall be sufficient grounds for the hospital to initiate collection efforts directed at the patient. Highline must notify persons applying for Charity Care in writing of its final eligibility determination within fourteen (14) calendar days of receiving a complete application, including one or more of the financial documentation identified above. Such determination must include a determination of the amount for which the Responsible Party will be held financially accountable.

In the event that Highline denies the application for Charity Care, Highline shall notify the Responsible Party in writing of the denial and the basis for the denial. All responsible parties denied Charity Care 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 documentation by the Highline Chief Financial Officer or equivalent. Responsible Parties shall be notified that they have thirty (30) calendar days within which to request an appeal of the final determination of Charity Care eligibility. Within the first fourteen (14) days of the appeal period, Highline may not refer the account to an external collection agency. After the fourteen (14) day period, if no appeal has been filed, Highline may initiate collection activities. If Highline initiates collection activities and thereafter discovers that an appeal has been filed, it will cease collectionefforts until the appeal is finalized.

In the event that Highline's final decision on appeal upholds the previous denial of Charity Care Eligibility, the Responsible Party and the Department of Health shall be notified in writing of the decision and the basis for the decision, and the Department of Health shall be provided with copies of documentation upon which the decision was based. Highline will make every reasonable effort to reach Charity Care eligibility determinations in a timely manner, and shall make such determinations at any time upon learning of facts or receiving financial documentation identified above indicating that the Responsible Party's income is equal to or below four hundred percent of the federal poverty standard, as adjusted for family size.

In the event that a Responsible Party pays a portion or all of the charges related to appropriate hospital-based medical care services, and is subsequently found to have met the Charity Care criteria at the time services were provided, any payments in excess of the amount eligible for discount shall be refunded to the patient within thirty days of establishing Charity Care eligibility.

If it is determined that a patient has financial resources which can be used to satisfy the medical liability but demonstrates an unwillingness to do so, the charity application will be denied.

CONFIDENTIALITY:
All information relating to the applications will be kept confidential. Copies of documents that support the application will be kept with the application form. All records will be retained for 7 years.

Effective Date: 9/04	Reviewed _____	Revised _____
Approved: Bud Musselman	Reviewed _____	Revised _____
	Reviewed _____	Revised _____

HIGHLINE MEDICAL CENTER
2009 CHARITY CARE SCHEDULE

Effective January 23, 2009

% CHARITY	100%	TO	80%	TO	60%	TO	40%	TO	20%
1	21,660		27,075		32,490		37,905		43,320
2	29,140		36,425		43,710		50,995		58,280
3	36,620		45,775		54,930		64,085		73,240
4	44,100		55,125		66,150		77,175		88,200
5	51,580		64,475		77,370		90,265		103,160
6	59,060		73,825		88,590		103,355		118,120
7	66,540		83,175		99,810		116,445		133,080
8	74,020		92,525		111,030		129,535		148,040
OVER 8	7,480		9,350		11,220		13,090		14,960

per family member

HIGHLINE MEDICAL CENTER
Main Campus

HIGHLINE MEDICAL CENTER
Specialty Campus

CHARITY CARE APPLICATION

Patient Name: _____ Account #_____

Date: _____

Dear Patient:

Thank you for choosing Highline Medical Center for your healthcare needs.

In accordance with the Washington State requirements of RCW 70.170, and WAC 246-453, Highline Medical Center is committed to providing appropriate urgent/emergency medical attention to all persons regardless of ability to pay. At Highline Medical Center, we are committed to providing charity care to patients who are uninsured or underinsured by offering free or sliding scale discounted services to qualified individuals. Eligibility for our charity care program is based upon the federal poverty guidelines.
Following these guidelines helps assure that we are making consistent and objective decisions about a patient's eligibility to receive charity care. Our goal is to link patients with the financial assistance that meets their needs while staying within the federal guidelines and our hospital policies.

If you feel you need assistance with paying your hospital bill, please complete and sign the "Financial Statement" with ONE of the following documents:

1) Most current year income tax return
2) Last three months pay stubs
3) Last three months bank statements
4) Letter of Support

Please return all information to the following address:

Highline Medical Center
Attn: Patient Accounting Department
PO Box 66657
Burien, WA 98166

Complete Information ***must*** be provided within 14 days to be considered.
Incomplete, inaccurate, or untimely applications may be denied.

Should you have any questions please call 206-988-5717 for assistance.

Highline Medical Center

PATIENT NAME(S) _____	DATE SENT _____
_____	DATE RETURNED _____
ACCOUNT NUMBER _____	DATE DETERMINED _____

FINANCIAL STATEMENT

HIGHLINE MEDICAL CENTER

RESPONSIBLE PARTY

NAME		MARITAL STATUS	SOCIAL SECURITY NUMBER
STREET ADDRESS, CITY, STATE, ZIP		HOW LONG AT THIS ADDRESS	HOME PHONE ( )
EMPLOYER NAME AND ADDRESS (IF UNEMPLOYED - HOW LONG)			BUSINESS PHONE ( )
POSITION / TITLE	MONTHLY INCOME - GROSS	MONTHLY INCOME - NET	LENGTH OF CURRENT EMPLOYMENT

SPOUSE

NAME			SOCIAL SECURITY NUMBER
EMPLOYER NAME AND ADDRESS (IF UNEMPLOYED - HOW LONG)			BUSINESS PHONE ( )
POSITION / TITLE	MONTHLY INCOME - GROSS	MONTHLY INCOME - NET	LENGTH OF CURRENT EMPLOYMENT

LIST OF CHILDREN LIVING AT HOME

NAMES AND YEAR OF BIRTH OF ALL PERSONS IN HOUSEHOLD (USE LINES PROVIDED BELOW)	TOTAL NUMBER OF PERSONS IN HOUSEHOLD	DO ANY OTHER PERSONS CONTRIBUTE FINANCIALLY TO THE FAMILY ☐ YES ☐ NO IF YES, AMOUNT $

MISCELLANEOUS INCOME PER MONTH

	$	CHILD SUPPORT / ALIMONY	$
PUBLIC ASSISTANCE / FOOD STAMPS	$	PENSIONS	$
SOCIAL SECURITY	$	RENTAL INCOME	$
UNEMPLOYMENT COMPENSATION	$		$
WORKMEN'S COMPENSATION	$		$
SAVINGS / CHECKING	$	OTHER (DESCRIBE)	$

ADDITIONAL INFORMATION

Current family monthly income (before taxes are taken out): $ _____

Total family income for the past three months (before taxes are taken out): $ _____

Have you recently suffered severe financial hardship or personal loss (for example, other medical expenses, death of a loved one, loss of home, auto or other property)? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do the documents that you are including with this application show your current financial situation correctly? ☐ Yes ☐ No

If no, why not? _____

_____

OFFICIAL USE ONLY

Income Considered $ _____

P.I.G. Allowance $ _____

☐ Approved Category _____ % ☐ Denied _____

Total Charges $ _____

Balance Due $ _____

IN COMPLETING THIS FINANCIAL STATEMENT, I HEREBY AFFIRM THAT THE ABOVE STATEMENTS ARE CORRECT AND COMPLETE, AND I GIVE MY CONSENT TO FURTHER VERIFICATION BY HIGHLINE MEDICAL CENTER OR ITS AGENTS. I AUTHORIZE HIGHLINE MEDICAL CENTER TO OBTAIN A CREDIT REPORT AND/OR TO CONTACT MY EMPLOYER FOR INCOME VERIFICATION IF DEEMED NECESSARY.

_____

Signature of Responsible Person Date

_____

Signature of Spouse Date