PURPOSE:
It is the policy of Willapa Harbor Hospital to establish guidelines for identifying patients eligible for uncompensated care based on their financial need.

Policy

Willapa Harbor Hospital is committed to the provision of health care services to all persons in need of medical attention regardless of their ability to pay. Consideration for Financial Assistance/Sliding Fee Scale is available to all persons regardless of race, color, sex, religion, age, or national origin. In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of Financial Assistance/Sliding Fee Scale, with the requirements of WAC 246-453, are established. This criteria will assist staff in making consistent and objective decisions regarding the eligibility for Financial Assistance/Sliding Fee Scale while ensuring the maintenance of a sound financial base. Additionally, the hospital has agreed to comply with the WSHA voluntary efforts on billing to the uninsured. All Financial Assistance/Sliding Fee Scale write offs will be approved by the CFO.

Communications to the Public

Willapa Harbor Hospital’s Financial Assistance Policy shall be made publicly available through the following elements:

1. Notices posted or prominently displayed within public areas of the hospital advising patients that financial assistance is provided.
2. Written notice of the availability of the Financial Assistance/Sliding Fee Scale will be made available to all patients. This is done at the time that the hospital requests information pertaining to third party coverage. This written information shall also be verbally explained at this time. If for some reason, for example in an emergency situation, the patient is not notified of the existence of the Financial Assistance/Sliding Fee Scale policy before receiving treatment, he/she shall be notified as soon as possible thereafter.
3. Written information about the hospital’s Financial Assistance/Sliding Fee Scale policy shall be made available to any person who requests the information.
4. The hospital shall train front-line staff to answer Financial Assistance/Sliding Fee Scale questions effectively or direct such inquiries to the appropriate department in a timely manner.

Eligibility Criteria

Financial Assistance is secondary to all other financial resources available to the patient, including all other third party payment sources. The guidelines used as criteria will include but not be limited to the following.
1. Persons eligible for Financial Assistance/Sliding Fee Scale will be comprised of those deemed to have undue financial hardships, considering income, resources, and obligations as determined by the hospital that make them unable to pay for all or a portion of their medical care. Such considerations will include a review of gross income and family size, and may also include other pertinent factors peculiar to each financial assistance request; such as net worth (including short and long term debts and liabilities) for those above 100% of the current federal poverty guidelines.

2. The full amount of hospital charges will be determined to be the basis for financial Assistance/Sliding Fee Scale for any patient whose gross family income is at or below 150% of the current federal poverty guidelines.

3. The following sliding fee schedule shall be used to determine the amount which shall be written off for patients with income levels between 151% and 250% of the current federal poverty level:

- 151% -- 170% Eighty percent (80%) Financial Assistance/Sliding Fee Scale patient max $ 990.00
- 171% -- 190% Sixty percent (60%) Financial Assistance/Sliding Fee Scale patient max $2,400.00
- 191% -- 210% Forty percent (40%) Financial Assistance/Sliding Fee Scale patient max $4,000.00
- 211% -- 230% Twenty five percent (25%) Financial Assistance/Sliding Fee Scale patient max $5,900.00
- 231% -- 250% Ten percent (10%) Financial Assistance/Sliding Fee Scale patient max $8,700.00

The responsible party's financial obligation which remains after the application of the sliding fee schedule may be payable in monthly installments over a reasonable period of time, without interest or late fees, as negotiated between the hospital and the responsible party.

4. Applicants residing in a nursing home, long term care facility, or custodial care facility with a disposable income of less than $150 per month may qualify for Financial Assistance/Sliding Fee Scale even if their income exceeds the guideline limit but is used for their principal care.

5. Prima Facie Write offs: The hospital may choose to grant financial Assistance/Sliding Fee Scale based solely on the initial determination. In such cases, the hospital will not complete full verification or documentation of any request.

6. Catastrophic Financial Assistance: The hospital may write off as Financial Assistance amounts for patients with family incomes in excess of the sliding fee schedule, or may provide a higher percentage adjustment within an income category when circumstances and/or large balance amount indicate severe financial hardship or personal loss.

7. Financial assistance may cover necessary or emergency medical treatment, received in the hospital inpatient or outpatient setting. Services not qualifying under financial assistance may include transportation cost, elective procedures, or separately billed professional services provided by the hospital’s medical staff. Non-residents of Washington State are eligible for Financial Assistance consistent with WAC 246-453-060, which includes emergent, non-scheduled services only.

Eligibility Determination
The hospital will make an initial determination of eligibility based on verbal or written application for Financial Assistance/Sliding Fee Scale. Pending final eligibility determination, the hospital will not initiate collection efforts or requests for deposits, provided 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.

1. The hospital shall use an application process for determining initial interest in and qualification for Financial Assistance/Sliding Fee Scale. Should patients not choose to apply for Financial Assistance/Sliding Fee Scale, they shall not be considered for Financial Assistance/Sliding Fee Scale unless other circumstances or intent become known to the hospital.

2. Requests to provide Financial Assistance/Sliding Fee Scale will be accepted from sources such as a 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 Financial Assistance/Sliding Fee Scale under this policy, it shall advise him or her of the potential and make an initial determination that such account is to be treated as Financial Assistance/Sliding Fee Scale.

Final Determination

The hospital will exercise the following options in making the final determination for Financial Assistance/Sliding Fee Scale:

1. Financial Assistance/Sliding Fee Scale forms shall be furnished to patients when Financial Assistance/Sliding Fee Scale is requested, when indicated, or when financial screen 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. One or more of the following types of documentation may be acceptable for purposes of verifying income:
   - W2 withholding statements for all employment during the relevant time period.
   - Pay stubs from all employment during the twelve (12) months prior to the date of request.
   - An income tax return from the most recently filed calendar year.
   - Forms approving or denying eligibility for Apple Care and/or state funded medical assistance.
   - Forms approving or denying unemployment compensation.
   - Written statements from employers or welfare agencies.

2. In the event that the responsible party is not able to provide any of the documentation described above, the hospital shall rely upon written and signed statements from the responsible party for making final determination of eligibility for classification as an indigent person.
3. Patients may be asked to provide verification or eligibility for Apple Health or other Medical Assistance. During the initial request period, the hospital may pursue other sources of funding, including Medicaid.

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

The hospital shall provide final determination within fourteen (14) days of receipt of the application and documentation.

Denial

When a patient’s application for Financial Assistance is denied, the patient will receive a written notice of denial which includes:

- The reason or reasons for the denial and the rules to support the hospital’s decision.
- The date of the decision; and
- Instructions for appeal or reconsideration.

When the applicant does not provide requested information and there is not enough information available for the hospital to determine eligibility, the denial notice also includes:

- A description of the information that was requested and not provided, including the date the information was requested;
- A statement that eligibility for Financial Assistance cannot be established based on information available to the hospital; and
- That eligibility will be determined if, within thirty days from the date of the denial notice, the applicant provides all specified information previously requested but not provided.

The patient or guarantor may appeal the determination of non-eligibility for Financial Assistance/Sliding Fee Scale by providing additional verification of income or family size to the hospital within thirty (30) days of receipt of notification. The Chief Financial Officer will review all appeals. If this determination affirms the previous denial, written notification will be sent to the patient or guarantor.

If a patient has been found eligible for Financial Assistance/Sliding Fee Scale and continues receiving services for an extended period of time without completing a new application, the hospital shall re-evaluate the patient’s eligibility for Financial Assistance/Sliding Fee Scale at least semi-annually to confirm that the patient remains eligible. The hospital may require the responsible party to submit a new Financial Assistance application and documentation.

Documentation and Records

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. Documents pertaining to Financial Assistance/Sliding Fee Scale shall be retained for six (6) years.
Willapa Harbor Hospital
Financial Assistance Application Form Instructions

This is an application for financial assistance at Willapa Harbor Hospital.

Washington State requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. Eligibility Criteria

Financial Assistance is secondary to all other financial resources available to the patient, including all other third party payment sources. The guidelines used as criteria will include but not be limited to the following.

1. Persons eligible for Financial Assistance/Sliding Fee Scale will be comprised of those deemed to have undue financial hardships, considering income, resources, and obligations as determined by the hospital that make them unable to pay for all or a portion of their medical care. Such considerations will include a review of gross income and family size, and may also include other pertinent factors peculiar to each financial assistance request; such as net worth (including short and long term debts and liabilities) for those above 100% of the current federal poverty guidelines.

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What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by Willapa Harbor Hospital and Pacific Family Health Center depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Willapa Harbor Hospital Business Office, 360-875-4503, 800 Alder Street South Bend, WA. 98586. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- Provide us information about your family
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Provide us information about your family’s gross monthly income (income before taxes and deductions)
- Provide documentation for family income and declare assets
- Attach additional information if needed
- Sign and date the form

Note: You do not have to provide a Social Security number to apply for financial assistance. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark “not applicable” or “NA.”

Mail or fax completed application with all documentation to: Willapa Harbor Hospital, PO Box 438 South Bend, WA 98586, or fax to 360-875-6167. Be sure to keep a copy for yourself.

To submit your completed application in person: Business Office, 800 Alder Street, 8:00 – 4:30, 360-875-4503.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly! You may receive bills until we receive your information.
Willapa Harbor Hospital
Financial Assistance Application Form — confidential

Please fill out all information completely. If it does not apply, write “NA.” Attach additional pages if needed.

### SCREENING INFORMATION

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need an interpreter?</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

*If Yes, list preferred language:

| Has the patient applied for Medicaid? | ☐ Yes | ☐ No |

*May be required to apply before being considered for financial assistance

| Does the patient receive state public services such as TANF, Basic Food, or WIC? | ☐ Yes | ☐ No |

| Is the patient currently homeless? | ☐ Yes | ☐ No |

| Is the patient’s medical care need related to a car accident or work injury? | ☐ Yes | ☐ No |

### PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

### PATIENT AND APPLICANT INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient first name</td>
<td>Patient middle name</td>
</tr>
<tr>
<td>Patient last name</td>
<td>Patient Social Security Number (optional*)</td>
</tr>
<tr>
<td>Female</td>
<td>Birth Date</td>
</tr>
<tr>
<td>Other (may specify __________)</td>
<td>Patient Social Security Number (optional*)</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Relationship to Patient</td>
</tr>
<tr>
<td>Relationship to Patient</td>
<td>Social Security Number (optional*)</td>
</tr>
<tr>
<td>Mailing Address</td>
<td>Main contact number(s)</td>
</tr>
<tr>
<td>City</td>
<td>Email Address:</td>
</tr>
<tr>
<td>State</td>
<td>( )</td>
</tr>
<tr>
<td>Zip Code</td>
<td>( )</td>
</tr>
</tbody>
</table>

Employment status of person responsible for paying bill:

<table>
<thead>
<tr>
<th>Status</th>
<th>Date of hire:</th>
<th>How long unemployed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
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<tr>
<td>Self-Employed</td>
<td></td>
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<tr>
<td>Student</td>
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<tr>
<td>Disabled</td>
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<tr>
<td>Retired</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

### FAMILY INFORMATION

List family members in your household, including you. “Family” includes people related by birth, marriage, or adoption who live together.

<table>
<thead>
<tr>
<th>FAMILY SIZE</th>
<th>Attach additional page if needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Date of Birth</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Relationship to Patient</th>
<th>If 18 years old or older: Employer(s) name or source of income</th>
<th>If 18 years old or older: Total gross monthly income (before taxes):</th>
<th>Also applying for financial assistance?</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<td></td>
<td>Yes / No</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Yes / No</td>
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</tbody>
</table>

All adult family members’ income must be disclosed. Sources of income include, for example:

- Wages
- Unemployment
- Self-employment
- Worker’s compensation
- Disability
- SSI
- Child/spousal support
- Work study programs (students)
- Pension
- Retirement account distributions
- Other (please explain ___________)

*(optional, but needed for more generous assistance above state law requirements)*
**INCOME INFORMATION**

**REMEMBER:** You must include proof of income with your application.

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

Examples of proof of income include:
- A "W-2" withholding statement; or
- Current pay stubs *(minimum necessary, no more than 3 months)*; or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

**EXPENSE INFORMATION**

We use this information to get a more complete picture of your financial situation.

<table>
<thead>
<tr>
<th>Monthly Household Expenses:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent/mortgage $</td>
<td>Medical expenses $</td>
</tr>
<tr>
<td>Insurance Premiums $</td>
<td>Utilities $</td>
</tr>
<tr>
<td>Other Debt/Expenses $</td>
<td><em>(child support, loans, medications, other)</em></td>
</tr>
</tbody>
</table>

**ASSET INFORMATION**

This information may be used if your income is above 101% of the Federal Poverty Guidelines.

<table>
<thead>
<tr>
<th>Current checking account balance $</th>
<th>Does your family have these other assets? Please check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current savings account balance $</td>
<td>□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)</td>
</tr>
<tr>
<td></td>
<td>□ Property (excluding primary residence) □ Own a business</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

**PATIENT AGREEMENT**

I understand that Willapa Harbor Hospital may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

Signature of Person Applying  
Date