PURPOSE:
Willapa Harbor Hospital 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 Financial Assistance, consistent with the requirements of Washington Administrative Code (WAC) 246-453, 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 basis.

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

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, which includes emergent, non-scheduled services only.

PROCEDURE:

ELIGIBILITY CRITERIA
Financial Assistance 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 Financial Assistance regardless of race, color, sex, religion, age, national origin, or immigration status. In the event that the responsible party’s identification as an indigent person is obvious to Hospital personnel, the Hospital is not obligated to establish the exact income level or request the documentation specified in the financial assistance application. Such individuals are determined to have presumptive eligibility (e.g., have qualified under the state Medicaid or Apple Health program.)

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

A. The full amount of hospital and/or clinic charges will be determined to be Financial Assistance for a patient whose gross family income is at or below 150% of the current federal poverty guidelines (consistent with WAC code 246-453-050). These patients shall receive a 100% adjustment on their patient balance.

B. A sliding fee scale shall be used to determine the amount which shall be written off for patients with incomes between 151% and 250% of the current federal poverty level. All resources of the family as defined by the WAC 246-453-30 are considered in determining the applicability of the sliding fee scale in Federal Poverty Guidelines-Appendix A. The sliding fee schedule shall take into account the potential necessity for allowing the responsible party to satisfy the maximum amount of charges for which the responsible party will be expected to provide payment over a reasonable period of time, without interest or late fees. In determining the maximum amount of charges, the Hospital calculates this by using the amounts Generally Billed (AGB) look-back methodology. For the current year, the Hospital’s AGB percentage is listed on Appendix A. No individual qualifying under the Financial Assistance Policy shall be charged more than the AGB for emergency care or other medically necessary services.

CATASTROPHIC FINANCIAL ASSISTANCE
The Hospital may also write off as Financial Assistance amounts for patients with family income in excess of 250% of the federal poverty standards or at a higher percentage for those above 150% 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 Hospital’s Board of Commissioners.

PROCESS FOR ELIGIBILITY DETERMINATION

Initial Determination
For the purpose of reaching an initial determination of eligibility, the Hospital shall rely upon information provided orally or in written form for Financial Assistance as outlined in the Financial Assistance Application form instructions. The Hospital may require the responsible party to sign a statement attesting to the accuracy of the information provided to the Hospital for purposes of the initial determination of eligibility. Pending final eligibility determination, the Hospital will not initiate collection efforts or requests 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 adequate documentation. The Hospital shall use an application process for determining initial interest in and qualification for Financial Assistance. Should patients not choose to apply for Financial Assistance, they shall not be considered for Financial Assistance unless other circumstances become known to the Hospital.

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.

Note that some independent providers practice at or deliver emergency or other medically necessary services for Hospital patients. Those providers are listed on Independent Providers-Appendix B.

Final Determinations
Financial Assistance forms, instructions, and written applications shall be furnished to patients when Financial Assistance 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;
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 Hospital may pursue other sources of funding, including Medicaid.

In the event that the patient is not able to provide any of the documentation described above, the Hospital shall rely upon written and signed statements from the patient for making a final determination of eligibility for purposes of granting Financial Assistance.

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 Hospital 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.

Financial Assistance will be granted based on the approval guidelines as outlined in Appendix A. The initial determination shall remain valid for 180 days. After that, the Hospital may request updated information or re-verification of the patient’s qualification status.

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.

Income verification is required as outlined in the Hospital's Financial Assistance Application form instructions.

For elective services not covered please contact the respective clinic or hospital department.

In the event of non-payment or a patient does not reasonably cooperate with the financial assistance process, the Hospital may take actions as outlined in its Patient Billing and Collection Policy; which is available by request and online.

Approvals

Financial Assistance applications will be approved once all required information is received and the income guidelines for granting Financial Assistance 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 (180) days from application approval date and will be retroactive for eligible services for all dates of service that the Financial Assistance is being granted.

In the event that a responsible party pays a portion of all of the charges related to appropriate hospital-based medical care services, and is subsequently found to have met the Financial Assistance criteria at the time that services were provided, any payments in excess of the amount determined to be appropriate in accordance with WAC 246-453-020 shall be refunded to the patient within thirty days of achieving the Financial Assistance designation.

Time Frame for Final Determination and Appeals

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

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.

Denials will be written and include instructions for appeal or reconsideration as follows. The patient/guarantor may appeal the determination of eligibility for Financial Assistance by providing additional verification of income and family size to the Patient Accounts Representative within (30) calendar days. After the first fourteen (14) days of this period, if no appeal has been filed, the hospital may initiate collection activities.

If the Hospital has initiated collection activities and discovers an appeal has been filed, they shall cease collection efforts until the appeal is finalized. All appeals will be reviewed by the Patient Accounts Representative and the Director, Business Office.

If this determination affirms the previous denial of Financial Assistance, 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 Financial Assistance shall be retained for six (6) years.

PROCESS FOR COMMUNICATION

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

A. Notices Posted or prominently displayed within public areas of the hospital advising patients that financial assistance is provided.

B. Written Notice of the availability of Financial Assistance/ Sliding fee Scale will be made available to all patients. This is done at the time that the hospital requests information about 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.

C. Written information about the Hospital's Financial Assistance/ Sliding Fee Scale policy shall be made available to any person who requests the information.

D. 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.
### APPENDIX A

Willapa Harbor Hospital Percentage of Sliding Fee Scale - 2019

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Federal Poverty Guideline</th>
<th>100% - 150%</th>
<th>151% - 170%</th>
<th>171% - 190%</th>
<th>191% - 210%</th>
<th>211% - 230%</th>
<th>231% - 250%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,490</td>
<td>$12,490</td>
<td>$17,486</td>
<td>$18,860</td>
<td>$21,358</td>
<td>$23,856</td>
<td>$26,229</td>
</tr>
<tr>
<td>4</td>
<td>$25,750</td>
<td>$25,750</td>
<td>$36,050</td>
<td>$38,883</td>
<td>$43,775</td>
<td>$44,033</td>
<td>$48,925</td>
</tr>
<tr>
<td>5</td>
<td>$30,170</td>
<td>$30,170</td>
<td>$42,238</td>
<td>$45,557</td>
<td>$51,289</td>
<td>$51,591</td>
<td>$57,323</td>
</tr>
<tr>
<td>6</td>
<td>$34,590</td>
<td>$34,590</td>
<td>$48,426</td>
<td>$52,231</td>
<td>$58,803</td>
<td>$59,149</td>
<td>$65,721</td>
</tr>
<tr>
<td>7</td>
<td>$39,010</td>
<td>$39,010</td>
<td>$54,614</td>
<td>$58,905</td>
<td>$66,317</td>
<td>$66,707</td>
<td>$74,119</td>
</tr>
<tr>
<td>8</td>
<td>$43,430</td>
<td>$43,430</td>
<td>$60,802</td>
<td>$65,579</td>
<td>$73,831</td>
<td>$74,265</td>
<td>$82,517</td>
</tr>
</tbody>
</table>

| Each Add'l person | $4,420 | $4,420 | $6,188 | $6,674 | $7,514 | $7,558 | $8,398 | $8,442 | $9,282 | $9,326 | $10,166 | $10,210 | $11,050 |
| Discount | 100% | 100% | 80% | 60% | 40% | 25% | 10% |

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(1) 2019 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

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### Appendix B

- Dr. Hovanscek – Podiatrist at Pacific Family Health Center
- Mark Scoons-Audiologist
- Dr. Hill- Work in our ER and we bill for, but has private practice on campus. Willapa Family Medicine.
- VRAD-contracted radiology Group Bills privately
- Callnetix-Pathology reference lab, private billing.

### References

<table>
<thead>
<tr>
<th>Reference Type</th>
<th>Title</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents referenced by this document</td>
<td>Federal Poverty Guideline Percentages -Attachment A</td>
<td>Federal Poverty Guideline Percentages -Attachment A</td>
</tr>
<tr>
<td>Referenced Documents</td>
<td>Federal Poverty Guidelines Attachment C</td>
<td>Federal Poverty Guidelines</td>
</tr>
<tr>
<td>Referenced Documents</td>
<td>Independent providers-Attachment B</td>
<td>Independent providers-Appendix B</td>
</tr>
</tbody>
</table>

Signed by

- Renee Clements, Director of Quality, Risk & Compliance (06/25/2019 07:27AM PST)
- Pam Ekman, Business Office Manager (06/25/2019 07:58AM PST)
- Kim McGee, Patient Registration Manager (07/01/2019 06:53AM PST)
- Eric Volk (07/08/2019 07:40AM PST)

Emmett Schuster, CEO (07/09/2019 09:26AM PST)

Effective

- 07/09/2019

Original Effective Date

- 01/24/2011
Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at https://www.lucidoc.com/cgi/doc-gw.pl?ref=whh:11004.
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></td>
<td></td>
</tr>
<tr>
<td>Has the patient applied for Medicaid?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient receive state public services such as TANF, Basic Food, or WIC?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient currently homeless?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient’s medical care need related to a car accident or work injury?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient first name</td>
<td></td>
</tr>
<tr>
<td>Patient middle name</td>
<td></td>
</tr>
<tr>
<td>Patient last name</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male / Female / Other</td>
</tr>
<tr>
<td>Birth Date</td>
<td></td>
</tr>
<tr>
<td>Patient Social Security Number (optional*)</td>
<td></td>
</tr>
<tr>
<td>Person Responsible for Paying Bill</td>
<td>Relationship to Patient</td>
</tr>
<tr>
<td>Mailing Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td>Employed / Unemployed / Self-Employed / Student / Disabled / Retired / Other</td>
</tr>
<tr>
<td>Main contact number(s)</td>
<td></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
</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>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>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes/No</td>
</tr>
</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)
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.

Monthly Household Expenses:

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent/mortgage</td>
<td>$</td>
</tr>
<tr>
<td>Insurance Premiums</td>
<td>$</td>
</tr>
<tr>
<td>Other Debt/Expenses</td>
<td>$</td>
</tr>
<tr>
<td>Medical expenses</td>
<td>$</td>
</tr>
<tr>
<td>Utilities</td>
<td>$</td>
</tr>
</tbody>
</table>

( child support, loans, medications, other)

ASSET INFORMATION

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current checking account balance</td>
<td>$</td>
</tr>
<tr>
<td>Current savings account balance</td>
<td>$</td>
</tr>
</tbody>
</table>

Does your family have these other assets?

Please check all that apply

- Stocks
- Bonds
- 401K
- Health Savings Account(s)
- Trust(s)
- Property (excluding primary residence)
- Own a business

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 ___________
Financial Assistance Instructions and Plain Language Summary

This is an application for financial assistance (also known as charity care) 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. Federal Poverty guidelines can be found on our website: http://willapaharborhospital.com.

No individual qualifying under the Financial Assistance Policy shall be charged more than the Amounts Generally Billed (AGB) for emergency care or other medically necessary services.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital/clinic based services provided by Willapa Harbor Hospital depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations. Elective services are not covered by the Financial Assistance Program (FAP).

If you have questions or need help completing this application: Please contact our Business Office at 360.875.4503. You may obtain a free copy of the Financial Assistance Policy and Application Form by mail and obtain help for any reason, including disability and language assistance. Spanish version of the FAP and plain language summary are available at the website or in the business office.

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, P. O. Box 438, South Bend, Washington 98586 or fax to: 360.875.6336. Be sure to keep a copy for yourself.

To submit your completed application in person, or if you have any questions about the process, you may visit us in person at: Business Office @ Willapa Harbor Hospital, 800 Alder St, South Bend WA, 98586. Office hours are: Monday - Friday 8:00am to 4:30pm. Phone: 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.

Financial Assistance Application
We want to help. Please submit your application promptly!
You may receive bills until we receive your information.

ELECTIVE SERVICES NOT COVERED BY FINANCIAL ASSISTANCE POLICY

In accordance with the Willapa Harbor Hospital Financial Assistance Policy, only certain services are covered for Financial Assistance. The Policy states:

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.

Services provided by Willapa Harbor Hospital which are not covered under the Financial Assistance Policy include, but are not limited to, the following elective procedures: (not an all-inclusive listing)

Cosmetic Procedures of any type (unless restorative and medically necessary)
Drug Screens (Industrial)
Orthopedic Surgery - Elective- Subject to appropriate hospital based medical services.
Pap and breast exam (always refer to Karen Hilburn or Breast and Cervical Health programs)- ok to cover by policy if the service is not covered by Karen Hilburn or Breast and Cervical)
Transportation Costs
Wart/Mole Removal

References

<table>
<thead>
<tr>
<th>Reference Type</th>
<th>Title</th>
<th>Notes</th>
</tr>
</thead>
</table>

Signed by

Renee Clements
Renee Clements, Director of Quality, Risk & Compliance
(06/21/2019 08:30AM PST)

Pam Ekman
Pam Ekman, Business Office Manager
(06/24/2019 07:54AM PST)

Kim McGee
Kim McGee, Patient Registration Manager
(07/01/2019 06:48AM PST)
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