PATIENT ACCOUNTS - POLICY

Title: Charity Care Policy
Number: PA 501
Effective Date: 08/12/2011
Revised Date: 11/8/2016, 7/30/2018, 09/08/23
Review Date (no revisions): 7/3/23

PURPOSE

Harbor Regional Health is committed to the provision of critical services to patient who do not have sufficient financial resources to pay for services rendered or to be rendered. In order to protect the integrity of operations and fulfill this commitment, HRH utilizes the following criteria for the provision of Charity Care.

POLICY

In recognition of the need of individuals with limited financial resources to obtain certain critical health care services, Grays Harbor County Public Hospital District No. 2 d/b/a Harbor Regional Health herewith adopts a Charity Care Program for Harbor Regional Health.

Charity Care will be granted to all eligible persons regardless of age, race, color, religion, sex, sexual orientation or national origin in accordance with WAC Chapter 246-453, RCW 70.170, and SHB1616.

ELIGIBILITY REQUIREMENTS

I. Patient with income within Harbor Regional Health's Poverty Guidelines (refer to Hospital's Sliding Fee Schedule A) which are based on the Federal Poverty Guideline.

CRITERIA FOR EVALUATION:

Requests for charity care will be accepted from any source. Typically that will be physicians, 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 will advise the patient of this potential and make an initial determination.

I. The patient indicates and appropriately and adequately demonstrates an inability to pay for services rendered or to be rendered. For all purposes of this Policy and the Program, all references to "patient" shall include, as may be applicable, the responsible party for the patient. The Program recognizes, addresses, and is limited to the needs of patients who are "indigent persons" as defined by WAC 246-453-010(4), which may include those who need assistance with medical bills due to temporary or permanent disability or inability to work as a result of catastrophic illness or injury.

   Under no circumstances will the Hospital deny access to emergency care to any individuals based on an inability to pay and/or inability to qualify for charity care.

II. Pursuant to WAC 246-453-010(7), services covered under the Program shall include only appropriate hospital-based or participating physician practice medical services. "Appropriate hospital-based medical services" shall mean those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available

or suitable for the person requesting the service. For this purpose, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

III. When a patient wishes to apply for charity care sponsorship in the Program, the Patient shall complete a Confidential Financial Information form ("CFI") and provide necessary and reasonable supplementary financial documentation to support the entries on the CFI. The application procedures shall not place an unreasonable burden upon the patient, taking into account any barriers which may hinder the patient's capability of complying with the application procedures.

A. Any of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care sponsorship status: a "W-2" withholding statement; pay stubs; an income tax return from the most recently filed calendar year; forms approving or denying unemployment compensation; or written statements from employers or welfare agencies. In the event the Patient 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 a final determination of eligibility for classification as an indigent person.

IV. Initial review of a patient's application and recommendation for approval of charity care sponsorship shall be the responsibility of appropriate hospital personnel, such as Patient Access, Social Work, or Patient Financial Services department. Patient Financial Services representative(s) shall make the "initial determination of sponsorship status," which means an indication, pending verification, that the services provided by the Hospital may or may not be covered by third party sponsorship, or an indication from the patient, pending verification, that he or she may meet the criteria for designation as an indigent person qualifying for charity care. Charity care determinations will preferably be made during pre-admission contacts but will be accepted during admission or at any other time. If the patient is unable to provide supporting documentation, the hospital may rely upon a written and signed statement from the patient. If it is obvious to hospital staff that a patient meets the criteria as an indigent person meeting the above income guidelines, it is not necessary to establish the exact income level or require supporting documentation. Examples of this might include an unemployed, homeless individual or someone whose eligibility has already been determined by a Community Health Clinic. An initial determination of sponsorship shall precede collection efforts directed at the patient, provided the patient is cooperative with the Hospital's efforts to reach an initial determination of sponsorship status. During the pendency, the Hospital may pursue reimbursement from any third-party coverage that may be available or identified to the Hospital.

V. A patient who has been initially determined to meet the criteria for Program sponsorship shall be provided with at least fourteen (14) days, or such time as the patient's medical condition may require, or such time as may be reasonably necessary, to secure and present documentation supporting status as an indigent person, in accordance with WAC 246-453-030, prior to receiving a final determination of Program eligibility. If the patient does not respond to the Hospital's reasonable requests for information and/or documentary evidence within fourteen (14) days (or such time as may be necessary considering the patient's medical condition), the Hospital may deem the charity care application incomplete and pursue such collection activity as it deems necessary and appropriate.

VI. In determining the status of a patient as an indigent person qualifying for charity care sponsorship in the Program, the Patient Financial Services Representative shall use the criteria set forth in RCW 70.170.060 and WAC 246-453-010 et.seq., which includes a family income (as defined in WAC 246-453-010(17) which is equal to or below 200% of the published federal poverty standards, adjusted for family size, or is otherwise not sufficient to enable payment for the care or to pay deductibles or coinsurance amounts required by a third-party payer. In accordance with WAC 246-453-010(4), the patient must also have exhausted any third party payment sources, including (but not limited to) Medicare and DSHS Medicaid.

A. Patients with family income equal to or below two hundred percent (200%) of the federal poverty standard, adjusted for family size, shall, pursuant to WAC 246-453-040(1) and SHB1616, be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship and provided that such patients are not eligible for other private or public health coverage sponsorship.

B. Patients with family income between two hundred-one and two hundred-fifty percent (201% - 250%) of the federal poverty standard, adjusted for family size, shall, pursuant to WAC 246-453-040(2) and SHB1616, be determined to be indigent persons qualifying for partial charity sponsorship of, which allows for discounts from charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship, in accordance with the Hospital's sliding fee schedule and policies regarding individual financial circumstances as set forth herein.

C. Patients with family income between three hundred-one and three hundred-fifty percent (251% - 300%) of the federal poverty standard, adjusted for family size, shall, pursuant to WAC 246-453-040(2) and SHB1616, be determined to be indigent persons qualifying for partial charity sponsorship of, which allows for discounts from charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship, in accordance with the Hospital's sliding fee schedule and policies regarding individual financial circumstances as set forth herein.

D. Pursuant to WAC 246-453-040(3), the Hospital may, in appropriate circumstances and in its sole discretion, classify a patient whose family income exceeds three hundred percent of the federal poverty standard, adjusted for family size, as an indigent person eligible for a discount from charges based upon the patient's individual financial circumstances.

VII. When the patient is eligible for and meets the guidelines and requirements for charity care sponsorship in the Program, the Patient Financial Services Representative shall forward such recommendation to the Patient Financial Services authorized designee for review. Within fourteen (14) days of receipt of all necessary information to make a final determination of Program eligibility, the Patient Financial Services designee shall notify the patient of the final determination, including a determination of the amount for which the patient will be held financially accountable.

VIII. In the event of a recommendation of denial of an application for charity care sponsorship in the Program, the Patient Financial Services Representative shall forward such recommendation to the Patient Financial Services authorized designee for review. The Patient Financial Services designee will, after review of all relevant information, make a final determination of sponsorship status of the patient. The final determination shall be made within fourteen (14) days of receipt of all necessary information.

IX. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income or family size to the Patient Financial Services department within thirty (30) days of receipt of notification. All appeals will be reviewed by the Patient Financial Services Director and the Chief Financial Officer or equivalent designee. 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. The failure of a patient to reasonably complete appropriate application procedures shall be sufficient grounds

for the Hospital to initiate collection efforts directed at the patient. Approval for charity care sponsorship will apply to the injury/illness currently being treated and extend to any other Hospital services that have been provided within a thirty (30) day period of time during which the patient qualifies for charity sponsorship in accordance with the Program. Hospital-based medical care services subsequently found to have met the charity care criteria at the time that services were rendered will be considered for Charity Care.

X. Assets are exempt and will not be considered in charity care qualification.

HOW TO APPLY

Any patient may apply to receive financial assistance/charity care by submitting an application and providing supporting documentation. If you have questions, need help, or would like to receive an application form or more information, please contact us:

- When you are checking in or checking out of the hospital;
- By telephone: 360-537-6101 Option 2 or 844-361-6044
- On our website at**: www.ghcares.org**
- In person: HRH Registration and/or Harbor Medical Group
- To obtain documents via mail free of charge: 915 Anderson Drive, Aberdeen, WA 98520

If English is Not Your First Language: Translated versions of the application form, financial assistance policy, and this summary, are available upon request.

Other Assistance:

Coverage assistance: You may be eligible for other government and community programs. We can help you research whether these programs (including Medicaid/Apple Health and Veterans Affairs benefits) can help cover your medical bills. We will assist you in applying for these programs.

Uninsured/Prompt Pay discounts: We offer a discount for patients who do not have health insurance coverage, as well as discounts for prompt payment of outstanding balances. Please contact us about our discount programs.

Payment plans: Any balance for amounts owed by you is due within 30 days. The balance can be paid in any of the following ways: credit card, payment plan, cash, check, or online bill pay. If you would like to set-u p a payment plan, please call the number on your billing statement.

MEDICAL STAFF AND ALLIED HEALTH PROFESSIONALS

Except as provided within this policy, Medical Staff members (and Allied Health Professionals) not employed by the Hospital are encouraged but not obligated to provide charity care in accordance with this Policy, and they may grant full or partial fee waivers in their discretion.

ATTACHMENTS

Attachment A: Financial Assistance Application and Confidential Financial Information Form
Attachment B: Schedule A: Grays Harbor Community Hospital Sliding Fee Schedule

Reviewing Body(ies): Board Finance Committee
Board of Commissioners

Approved By:

Executive Director Revenue Cycle Services	Date
Chief Financial Officer	Date

Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as Charity Care) at Grays Harbor Community 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.

What does financial assistance cover? The Hospital financial assistance program covers appropriate hospital-based services provided by Grays Harbor Community Hospital as well as clinic services provided by Harbor Medical Group 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: Grays Harbor Community Hospital Financial Counselors office 360-537-6101 Option 2 or 1-844-361-6044 @ 915 Anderson Drive, Aberdeen, WA 98520. 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)**
  This may include: pay stubs, quarterly taxes, social security etc.
- □ **Attach additional information if needed**
- □ **Sign and date the form**

Mail or fax completed application with all documentation to: Grays Harbor Community Hospital, 915 Anderson Drive, Aberdeen WA., 98520. Fax applications to 360-537-4177. Be sure to keep a copy for yourself.

To submit your completed application in person: GHCH Patient Accounts Department between the hours of 8-4:30
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.

Charity Care/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
Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*
Has the patient applied for Medicaid? □ **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			
Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify _____)	Birth Date		
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	
Mailing Address _____ _____ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____
Employment status of person responsible for paying bill □ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____) □ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)			

FAMILY INFORMATION					
List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. **FAMILY SIZE _____** *Attach additional page if needed*					
Name	Date of Birth		If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	

All adult family members' income must be disclosed. Sources of income include, for example but not limited to:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Student grants and financial assistance- Pension - Retirement account distributions
- Other (*please explain_____)*

Charity Care/Financial Assistance Application Form – confidential

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 for *3 months*;
- Last year's income tax return, including schedules if applicable;
- Written, signed statements from employers or others;
- 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.

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 Grays Harbor Community 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

Size of Family	Federal Poverty Yearly Guidelines (100%)	GHCH/Federal Poverty Yearly Guidelines (200%)	Charity Write Off (Sliding Scale)	GHCH/Federal Poverty Yearly Guidelines (201%-250%)	Charity Write Off (Sliding Scale)	GHCH/Federal Poverty Yearly Guidelines (251%-300%)	Charity Write Off (Sliding Scale)
1	$14,580.00	$29,160.00	100%	$36,450.00	75%	$43,740.00	50%
2	$19,720.00	$39,440.00	100%	$49,300.00	75%	$59,160.00	50%
3	$24,860.00	$49,720.00	100%	$62,150.00	75%	$74,580.00	50%
4	$30,000.00	$60,000.00	100%	$75,000.00	75%	$90,000.00	50%
5	$35,140.00	$70,280.00	100%	$87,850.00	75%	$105,420.00	50%
6	$40,280.00	$80,560.00	100%	$100,700.00	75%	$120,840.00	50%
7	$45,280.00	$90,560.00	100%	$113,200.00	75%	$135,840.00	50%
8	$50,560.00	$101,120.00	100%	$126,400.00	75%	$151,680.00	50%

Tamaño de la familia	Parámetros Federales de Pobreza Anuales	GHCH/Parámetros Federales de Pobreza Anuales (200%)	Descuento de Caridad (Escala Móvil de Pago)	GHCH/Parámetros Federales Anuales (201%-251%)	Descuento de Caridad (Escala Móvil de Pago)	GHCH/Parámetros Federales Anuales (251%-300%)	Descuento de Caridad (Escala Móvil de Pago)
1	$14,580.00	$29,160.00	100%	$36,450.00	75%	$43,740.00	50%
2	$19,720.00	$39,440.00	100%	$49,300.00	75%	$59,160.00	50%
3	$24,860.00	$49,720.00	100%	$62,150.00	75%	$74,580.00	50%
4	$30,000.00	$60,000.00	100%	$75,000.00	75%	$90,000.00	50%
5	$35,140.00	$70,280.00	100%	$87,850.00	75%	$105,420.00	50%
6	$40,280.00	$80,560.00	100%	$100,700.00	75%	$120,840.00	50%
7	$45,280.00	$90,560.00	100%	$113,200.00	75%	$135,840.00	50%
8	$50,560.00	$101,120.00	100%	$126,400.00	75%	$151,680.00	50%