CHARITY CARE / FINANCIAL ASSISTANCE FOR THE UNINSURED AND UNDERINSURED

PURPOSE

This Financial Assistance Policy is intended to ensure that residents of Washington State who are at or near the federal poverty level receive Appropriate Hospital-Based Medical Services and Appropriate Non-Hospital-Based Medical Services at a cost that is based on their ability to pay for services up to and including care without charge. Financial Assistance 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 and RCW 70.170.

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

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 elective or experimental 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. Financial Assistance will not be denied based on immigration status.

POLICY AVAILABILITY

Lake Chelan Health is required to provide notice of its Financial Assistance program and will make a good faith effort to provide every patient with information regarding its availability. Lake Chelan Health (inpatient and hospital-based outpatient clinics/facilities) will post signs in Patient Access, Business Office/Financial Counseling, Emergency Department and Outpatient Registration that will notify the public of the Financial Assistance Policy. Eligibility for Financial Assistance requires that patients must fulfill all requirements and expectations as outlined in the Financial Assistance Policy. This Financial Assistance Policy and applications for Financial Assistance are available in any language spoken by the lesser of five percent of the population or 1,000 individuals in the applicable hospital's service area. Additionally, interpreter services will be made available for other non-English speaking or limited-English speaking or other patients who cannot read or understand the written application materials

1) ELIGIBILITY CRITERIA

Initial Determination

For the purpose of reaching an initial determination of eligibility, the District shall rely upon information provided orally or in written form for Financial Assistance as outlined in the Financial Assistance Application Form Instructions. The District may require the responsible party to sign a statement attesting to the accuracy of the information provided to the District for purposes of the initial determination of eligibility.

Patients will be screened for other forms of coverage such as Medicaid and Health Benefits Exchange eligibility.

This application, along with full disclosure of their financial status with supporting documentation, will be considered in the final determination of eligibility.

Lake Chelan Health will not initiate collection efforts until an initial determination of Financial Assistance eligibility status is made. Where Lake Chelan Health initially determines that a patient may be eligible for Financial Assistance, any and all extraordinary collection actions (including civil actions, garnishments, and reports to collections or credit agencies) shall cease pending a final determination of Financial Assistance eligibility. However, as set forth in WAC 246-453-020

(5), the failure of a patient or responsible party to reasonably complete Financial Assistance application procedures under this policy shall be sufficient grounds for Lake Chelan Health to initiate collection efforts directed at the patient. Accordingly, for purposes of this policy, a patient or responsible party has failed to reasonably complete financial assistance application procedures when the patient or responsible party does not submit application materials within 15 business days of the patient's or responsible party's receipt of the materials. Any collection efforts will be halted if the patient or responsible party reengages in the application process.

Third-Party Coverage

Financial Assistance is generally secondary to all other third-party coverage resources available to the patient.

This includes:

1. Group or individual medical plans.
2. Workers' compensation programs.
3. Medicare, Medicaid or other medical assistance programs.
4. Other state, federal or military programs.
5. Third-party liability situations. (e.g.: auto accidents or personal injuries).
6. Tribal health benefits.
7. Health care sharing ministry as defined in 26 U.S.C. Sec. 5000A.
8. Other situations in which another person or entity may have 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 District personnel, the District 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 District policy based on the following criteria consistent with requirements of WAC 246-453-040.

Income

By policy, persons whose income is equal to or below 400% of the federal poverty standard may be eligible to receive Financial Assistance. Lake Chelan Health will consider all sources of income in establishing income eligibility for Financial Assistance. Income includes: total cash receipts before taxes derived from wages and salaries; welfare payments; Social Security payments; strike benefits; unemployment or disability benefits; child support; alimony; and net earnings from business and investment activities paid to the individual patient/guarantor.

1. 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 100% of the current federal poverty guidelines (consistent with WAC code 246-453-050. These patients shall receive a 100% adjustment on their patient balance.

2. A sliding fee scale shall be used to determine the amount which shall be written off for patients with incomes between 101% and 400% of the current federal poverty level. All resources of the family as defined by WAC 246-453-050 are considered in determining the applicability of the sliding fee scale in **Attachment A.**

3. The sliding fee scale 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 District calculates this by using the Amounts Generally Billed (AGB) look-back methodology. For the current year, the District's AGB percentage is listed on **Attachment A** (enclosed). No individual qualifying under the Financial Assistance Policy shall be charged more than the AGB for emergency care of other medically necessary services. *See* 26 USC §501(r)(5)(A)

Catastrophic Financial Assistance

The District may also write off, as Financial Assistance, amounts for patients with family income in excess of 400% of the federal poverty level or at a higher percentage for those above 100% of the federal poverty guidelines, when circumstances indicate severe financial hardship or personal loss. This will be done only upon recommendation by the business office manager with adequate justification and only upon approval by the Chief Financial Officer. These adjustments shall be included in the Chief Financial Officer's regular financial assistance report to the Board of Commissioners.

DEFINITIONS

Residence and Scope of Services:
A person is not a Washington State resident and is not eligible for Financial Assistance when that person enters Washington State solely for the purpose of seeking medical care. Refugees, asylees, and those seeking asylum are exempt from the Washington State residency requirement for Financial Assistance eligibility. Alsoexempt from the Washington State residency requirement are those patients who have an Emergency Medical Condition. Financial Assistance will not be denied based on immigration status. Exceptions to residence and scope ofservices requirements outlined in this paragraph may be made only in extraordinary circumstances and with the approval of the Lake Chelan Health Chief Financial Officer or designee. While not required by federal or state law, eligibility for Financial Assistance will be extended to individuals who receive Appropriate Non-Hospital Based Medical Servicesand meet the above criteria

Financial Assistance: Medically necessary hospital health care rendered to indigent persons when Third-Party Coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductible or coinsurance amounts required by a third-party payer based on the criteria in this policy. Persons who have exhausted any third-party coverage, 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 payer, may be eligible for Financial Assistance under this policy.

Appropriate Hospital-Based Medical Services: Those Lake Chelan Health hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or 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. A course of treatment may include mere observation or, where appropriate, no treatment at all.

Appropriate Non-Hospital Based Medical Services: Those services rendered at the clinic offices by LCH Members. which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or 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. A course of treatment may include mere observation or, where appropriate, no treatment at all. For purposes of this Financial Assistance Policy, preventive care services may be considered "Appropriate Non-Hospital-Based Medical Services".

LCH Members: For purposes of this policy, a physician or other qualified healthcare professional who has executed a practice agreement with LCH, or has otherwise reassigned their services to LCH under a contractual arrangement, and provides services at approved LCH sites of practice.

2) APPLICATION

When a patient wishes to apply for Financial Assistance, the patient shall complete a Confidential Financial Information (CFI) Form **(Attachment B)** and provide necessary and reasonable supplementary financial documentation to support the entries on the CFI. Lake Chelan Health will make an initial determination of a patient's Financial Assistance status at

the time of admission or as soon as possible following the initiation of services to the patient. Financial Assistance 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. Screening for eligibility for Medicaid or other relevant public assistance benefits will be coordinated through the Patient Access Department, Discharge Planning/Outcomes Management (if not nursing home placement) or through Patient Financial Services.

1. Any one of the following documents shall be considered sufficient evidence upon which to base the final determination of Financial Assistance eligibility:
    a. "W-2" withholding statement;
    b. Current pay stubs (3 months);
    c. Bank statements (3 months);
    d. Last year's income tax return, including schedules, if applicable;
    e. Written, signed statements from employers or others (letter of support) stating your current financial situation and circumstances if you have no proof of income;
    f. Forms approving or denying eligibility for Medicaid and/or state funded medical assistance;
    g. Forms approving or denying unemployment compensation; or written statements from employers or welfare agencies.
2. In addition, in the event the patient is not able to provide any of the documents described above, Lake Chelan Health shall rely upon written and signed statements from either the responsible party or another party describing the applicant's income. If none of the above is available, Lake Chelan Health may make a determination based on knowledge of a prior grant of financial assistance or based on verbal representation.

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

4. Lake Chelan Health may waive income requirements, documentation and verification if Financial Assistance eligibility is obvious. Lake Chelan Health staff discretion will be exercised in situations where factors such as social or health issues exist. In such cases, Lake Chelan Health shall rely upon written and signed statements from the responsible party for making a final determination of eligibility.

5. Lake Chelan Health shall make a final determination within 14 days of receipt of financial assistance applications and supporting documentation. Supporting documentation includes items listed on the Confidential Financial Information Form Instructions.

Notifications

Lake Chelan Health shall notify persons applying for Financial Assistance of its determination of eligibility for Financial Assistance within 14 days of a receiving person's completed application for Financial Assistance and supporting documentation. Approvals, Requests for More Information or Denials for Financial Assistance applications shall be in writing and shall include instructions for appeal or reconsideration. In the event that Lake Chelan Health denies Financial Assistance, Lake Chelan Health shall notify the person applying for Financial Assistance of thebasis for the denial. If denied the patient/guarantor may provide additional documentation to Lake Chelan Health or request review by the Chief Financial Officer or their designee within 30 days of receipt of the notification of denial. If this review 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 of Records

All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the financial assistance application form and retained for seven years.

CROSS REFERENCE

- Washington Administrative Code, Chapter 246-453, “Hospital Financial Assistance” with specific reference to the following:
    - WAC 246-453-020 Uniform procedures for the identification of indigent persons
    - WAC 246-453-030 Data requirements for the identification of indigent persons
    - WAC 246-453-040 Uniform criteria for the identification of indigent persons
- RCW 70.170.060 Financial Assistance — Prohibited and required hospital practices and policies
- 26 USC §501(r)(5)(A) and (B)
- Lake Chelan Health Billing & Collection Policy
- Lake Chelan Health (Policy Stat ID 8989696 – “Duty to Provide Appropriate Medical Screen Examination Policy (CAH) - EmergencyMedical Treatment and Active Labor Act (EMTALA)”

ATTACHMENTS:

Attachment A: Federal Poverty Guidelines/Sliding Fee Scale
Attachment B: Financial Assistance Application / Confidential Financial Information (CFI) Form

REVIEW/REVISION DATES: 5/8/2017, 11/18/2021

CHARITY CARE ELIGBILITY GUIDELINE
PAYMENT SCHEDULE

Lake Chelan Health

Maximum amount patient would be required to pay based on gross monthly earnings and number of family members.

FAMILY SIZE	FPL	100% FPL		100% TO 150% FPL		151% TO 200% FPL		201% TO 250% FPL		200% TO 300% FPL		300% - 400% FPL		OVER 400% FPL	
	DISCOUNT	100%		95%		90%		80%		65%		50%		0%	
1	$ 12,880.00	$ -	$ 1,073	$ 1,074	$ 1,610	$ 1,611	$ 2,147	$ 2,148	$ 2,683	$ 2,684	$ 3,220	$ 3,221	$ 4,293	$ 4,294	&OVER
2	$ 17,420.00	$ -	$ 1,452	$ 1,453	$ 2,178	$ 2,179	$ 2,903	$ 2,904	$ 3,629	$ 3,630	$ 4,355	$ 4,356	$ 5,807	$ 5,808	&OVER
3	$ 21,960.00	$ -	$ 1,830	$ 1,831	$ 2,745	$ 2,746	$ 3,660	$ 3,661	$ 4,575	$ 4,576	$ 5,490	$ 5,491	$ 7,320	$ 7,321	&OVER
4	$ 26,500.00	$ -	$ 2,208	$ 2,209	$ 3,313	$ 3,314	$ 4,417	$ 4,418	$ 5,521	$ 5,522	$ 6,625	$ 6,626	$ 8,833	$ 8,834	&OVER
5	$ 31,040.00	$ -	$ 2,587	$ 2,588	$ 3,880	$ 3,881	$ 5,173	$ 5,174	$ 6,467	$ 6,468	$ 7,760	$ 7,761	$ 10,347	$ 10,348	&OVER
6	$ 35,580.00	$ -	$ 2,965	$ 2,966	$ 4,448	$ 4,449	$ 5,930	$ 5,931	$ 7,413	$ 7,414	$ 8,895	$ 8,896	$ 11,860	$ 11,861	&OVER
7	$ 40,120.00	$ -	$ 3,343	$ 3,344	$ 5,015	$ 5,016	$ 6,687	$ 6,688	$ 8,358	$ 8,359	$ 10,030	$ 10,031	$ 13,373	$ 13,374	&OVER
8	$ 44,660.00	$ -	$ 3,722	$ 3,723	$ 5,583	$ 5,584	$ 7,443	$ 7,444	$ 9,304	$ 9,305	$ 11,165	$ 11,166	$ 14,887	$ 14,888	&OVER

For families/households with more than 8 persons, add $4,540 for each additional person.

District's Amounts Generally Billed (AGB) Percentage

53.77%

Based on 2021 Federal Poverty Guidelines
Revised 01-2021

Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at Lake Chelan Health.

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. Please see hospital's policy at https://lakechelanhealth.org/for-patients-families-2/patient-billing-services/.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based and non-hospital based services provided by Lake Chelan Health, 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: Please call (509) 682-6103 with any questions that you may have. 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)**
- ☐ **Attach additional information if needed**
- ☐ **Sign and date the form**

Mail or fax completed application with all documentation to: Lake Chelan Health P.O. Box 908, Chelan, WA 98816. Fax: (509) 682-3432. Be sure to keep a copy for yourself.

To submit your completed application in person: Business Office, 503 E Highland Ave, Chelan WA 98816
(509) 682-3300. Direct line for questions is (509) 682-6103.

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**

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

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	Relationship to Patient	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):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

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*______________)

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. <u>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.</u>

<u>Examples of proof of income include:</u>

- A "W-2" withholding statement; or
- Current pay stubs (*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.

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 Lake Chelan Health 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