Financial Assistance Policy (BP-018)

Purpose:
To help low income people and families pay for hospital medical services. Financial assistance is either free care or reduced-price care, depending on household size and income.

Policy/Procedure:
This policy/procedure describes Othello Community Hospital's financial assistance program, and is effective as of July 1, 2022

Mission
Othello Community Hospital (OCH) is committed to the provision of 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 charity care, consistent with the requirements of RCW Chapter 70.170, the applicable sections of WAC Chapter 246-453, and the voluntary effort of the Washington State Hospital Association, 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 base. Charity care and/or financial assistance refer to free or reduced prices for care based on income.

Charity care and/or financial assistance will be granted regardless of race, color, sex, religion, age, national origin, creed, marital status, physical or mental disability, sexual orientation, and veteran status.

Criteria for Financial Assistance and Charity Care
For medically necessary hospital care received on or after July 1, 2022, Othello Community Hospital will consider patients for financial assistance and charity under this policy once third party coverage, if any, has been exhausted. The following criteria will be applied:

1. The full amount (100%) of patient/guarantor responsibility for hospital charges will be determined to be charity care for a patient/guarantor whose household income is at or below 200% of the current federal poverty level, adjusted for household size.
2. Seventy-five percent of patient/guarantor responsibility for hospital charges will be determined to be charity care for a patient/guarantor whose household income is between 201% and 250% of the current federal poverty level, adjusted for household size.
3. Fifty percent of patient/guarantor responsibility for hospital charges will be determined to be charity care for a patient/guarantor whose household income is between 251% and 300% of the current federal poverty level, adjusted for household size.

Eligibility Determination

1. **Initial Determination:** During the patient registration process, the hospital will make an initial determination of eligibility based on verbal or written application for charity care. Pending final eligibility determination, the hospital will not initiate collection efforts or request for deposits,

provided that the responsible party is cooperative with the hospital's efforts to reach a determination of eligibility status, including return of applications and documentation within fourteen (14) days of receipt. Additional time may be allowed for the return of applications and documentation in consideration of special circumstances, such as medical condition and/or difficulty obtaining documentation. While the hospital will endeavor to provide reasonable assistance, it is ultimately the responsibility of the patient/guarantor to complete the charity care application and to provide financial information when requested to do so by the hospital.

The hospital will use an application process for determining initial interest in and qualification for charity care. Requests to provide charity care will be accepted from sources such as physician, community or religious groups, social services, financial services personnel, or the patient/guarantor. If the hospital becomes aware of factors which might qualify the patient for charity care under this policy, it shall advise him or her of this potential and make an initial determination that such account is to be treated as charity care.

2. Final Determination:

a. **Prima Facie Write-Offs –** The hospital may choose to grant charity care based solely on the initial determination. In such cases, the hospital will not complete full verification or documentation of any request.

b. **Application and Income Verification –** Charity care/financial assistance forms and instructions will be furnished to patients when charity care is requested or when financial screening indicates potential need. Information about the availability of financial assistance will be provided in first billings sent to patient/guarantor home addresses. All applications, whether initiated by the patient or the hospital, should be accompanied by documentation to verify income amounts indicated on the application form. For current accounts (dates of service within 12 months prior to the application date), patients will be considered for charity care under this policy based on household size and documented income for the 12 months prior to the day of request. Consideration for eligibility does not include assets, only household income. One or more of the following types of documentation may be acceptable for purposes of verifying income:

   i. W-2 withholding statements for all employment during the relevant time period.
   ii. Pay stubs from all employment during the relevant time periods.
   iii. An income tax return from the period related to the date of the service provided. If a tax return is not available for the current period, one may be used from the previous year.
   iv. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance.
   v. Forms approving or denying unemployment compensation.
   vi. Written statements from employers or welfare agencies.

c. **Income Annualization –** Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. The annualization process will be determined by the hospital and will take into consideration seasonal employment and temporary increases and/or decreases in income.

d. **Household Income –** Income will be considered from all family members listed as living in a household. "Income" means 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. "Family" means a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family.

e. **Eligibility for Certain Third-Party Coverage –** The following procedures will apply for identifying patients/guarantors who may be eligible for health care coverage through Washington medical assistance programs (Medicaid/Apple Health) or the Washington Health Benefit Exchange:

   i. As part of the process of determining the patient/guarantor financial obligation and eligibility for charity care, the hospital will inquire as to whether a patient/guarantor meets criteria for health care coverage under medical assistance programs as described in RCW 74.09, or for the Washington Health Benefit Exchange.

   ii. If information in the charity care application indicates that the patient /guarantor may be eligible for coverage under these programs, the hospital will assist the patient/guarantor in applying for coverage. Per the needs of each patient/guarantor, this may include walking them through the application process, answering questions, providing them with appropriate forms and/or literature about the program, and/or helping them contact local agency representatives for those programs, among other things.

   iii. The hospital may set a reasonable time limit (normally up to 14 days) for the patient/guarantor to follow through in applying for coverage under these programs. In setting such limit, the hospital will take into account any physical, intellectual, or sensory deficiencies, or language or other barriers which may hinder the patient/guarantor. If the patient/guarantor fails to make a reasonable effort to comply with the time limit, the hospital will not be obligated to provide charity care.

   iv. If a patient/guarantor is obviously or categorically ineligible for these programs, or has been deemed ineligible for coverage in the prior 12 months, the hospital will not require the patient/guarantor to apply for such coverage as an eligibility condition for charity care.

f. **Assistance Determination on Old Accounts –** Patients may apply for charity care on old accounts. The application and the financial information need to pertain to the year in which the service was provided. Determination of charity eligibility for old accounts will be based on federal poverty guidelines for the year services were provided. If there are multiple accounts in multiple years, an application and financial information need to be provided for each year. If a single account has charges crossing two years, then eligibility and discount will be determined based on the year with the bulk of the charges, or on the earlier year if the charge amounts in each year are equal.

3. **Time Frame for Final Determination:** The hospital will provide final determination of charity eligibility and amounts within fourteen (14) days of receipt of all requested application and documentation material.

4. **Application Denials and Appeals:** Denials will be made in writing and will include instructions for appeal or reconsideration. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income or family size to the Business Office Manager within thirty (30) days of receipt of notification. In the event an appeal is filed, any

collection action previously initiated on the appellant accounts will be suspended pending reconsideration and final determination. All appeals will be reviewed by the Director of Finance and/or Administrator. If this determination affirms the previous denial of charity care, written notification will be sent to the patient/guarantor and to the Department of Health in accordance with state law.

5. **Payment of Remaining Financial Obligation:** The financial obligation of the patient/guarantor which remains after the application of this policy may be paid in monthly installments over a reasonable period of time, without interest or late fees, as negotiated between the hospital and the patient/responsible party. Patients/guarantors may be referred for collection action if they do not uphold their agreed payment schedule. In such event, patients/guarantors may not reapply for financial assistance on the same accounts previously considered.

6. **Refunds:** In the event that a patient or responsible party pays a portion or all of the charges on an account and is subsequently found to have met the charity care criteria at the time services were provided, any payments exceeding their financial obligation will be refunded within thirty days of the eligibility determination. This does not apply to accounts for which legal action has been initiated under the normal collection process.

Severe Hardships

The hospital may also write off as charity care amounts for patients with family income in excess of 300 percent of the federal poverty standard when circumstances indicate severe financial hardship or personal loss.

Notification

Othello Community Hospital will provide written notice to all patients informing them about the availability of financial assistance. Othello Community Hospital will post signs publicizing the availability of financial assistance in English and Spanish. This policy, or a “plain language” version, will also be made available in English and Spanish to those so requesting.

Collection Practices

The Othello Community Hospital Board of Commissioners will receive an annual summary report on collection actions taken.

With respect to the turning over of accounts to collection, the following will occur on a monthly basis: 1) The hospital's business office manager will submit a list of accounts to the CFO and/or CEO for review and/or modification; 2) the CFO and/or CEO will then submit the list of accounts to the Finance Committee for review and/or modification; 3) the Finance Committee will submit a summary report to the Board of Commissioners; 4) the Board will render decision.

With respect to the filing of liens on primary residences, the following will occur: 1) The hospital's collection agency will first submit a recommendation to the CFO and/or CEO for review and/or modification; 2) the CFO and/or CEO will then submit a recommendation to the Finance Committee for review and/or modification; 3) the Finance Committee will submit a recommendation to the Board of Commissioners for review and/or modification; 4) the full Board will render a final decision.

Confidentiality, Documentation, and Retention of Records

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 charity care shall be retained for seven (7) years.

Staff Training

All relevant and appropriate staff shall participate in standardized training based on this policy, and on the use of interpreter services to assist persons with limited English proficiency and non-English-speaking persons in understanding information about the availability of financial assistance. The training will help to ensure staff can answer financial assistance questions effectively, obtain necessary interpreter services, and direct inquiries in an appropriate and timely manner.