DEPARTMENT: ADMINISTRATION
POLICY & PROCEDURE: FINANCIAL ASSISTANCE

PURPOSE:
Ocean Beach Health (the "District") 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 Financial Assistance, consistent with the requirements of Washington Administrative Code (WAC) 246-453, have been 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 District will publicize the policy with the community serviced 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 transportation costs, elective procedures, or separately billable professional services provided by the hospital's medical staff.

In addition to providing Financial Assistance, the District also identifies and assists eligible uninsured patients with enrollment in Medicaid or coverage available on the Washington Health Benefit Exchange (HBE). This includes the generation of self-pay patient lists, contacting those uninsured patients and then attempting to obtain enrollment through the efforts of the District's In-Person Assistor team.

ELIGIBILITY CRITERIA
Financial Assistance is generally secondary to all other financial resources available to the patient, including but not limited to 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 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:

For those patients that have been identified to meet the guidelines for an Apple Health plan, they will need to comply with the application process prior to receiving financial assistance.

A. For services provided, the full amount of District hospital and/or clinic charges will be determined to be Financial Assistance for a patient whose gross family income is at or below 200% of the current federal poverty guidelines (consistent with WAC code 246-453-050). These patients shall receive a 100% adjustment on their patient balance. The District will not consider the existence, availability or value of assets for patients in this category.
B. For services provided, a sliding fee scale shall be used to determine the amount which shall be written off for patients with incomes between 201% and 300% of the current federal poverty level. All resources of the family as defined by the WAC 246-453-50 are considered in determining the applicability of the sliding fee scale.
C. The sliding fee schedule shall take into account the potential necessity for allowing the party responsible to satisfy the maximum amount of charges for which the party responsible 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 or other medically necessary services.

CATASTROPHIC FINANCIAL ASSISTANCE

The District may also write off as Financial Assistance amounts for patients with family income in excess of 300% of the federal poverty standards or at a higher percentage for those above 200% of the poverty guidelines, when circumstances indicate severe financial hardship or personal loss. This will be done only upon recommendation by the patient accounts supervisor or Director, Business Office with adequate justification and only upon approval by the Senior Director Revenue Cycle, with final approval by the Controller and/or the Chief Financial Officer. These adjustments shall be included in the Chief Financial Officer's regular financial assistance report to the Board of Commissioners.

PROCESS FOR ELIGIBILITY DETERMINATION

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 party responsible to sign a statement attesting to the accuracy of the information provided to the District for purposes of the initial determination of eligibility. Pending final eligibility determination, the District will not initiate collection efforts or requests deposits, providing that the responsible party is cooperative with the District's efforts to reach a determination of sponsorship status, including return of applications and adequate documentation.

The District shall use an application process for determining initial interest in and qualification for Financial Assistance. Application instructions are provided below in Section F. Should patients not choose to apply for Financial Assistance, they shall not be considered for Financial Assistance unless other circumstances become known to the District.

Note that some independent providers practice at or deliver emergency or other medically necessary services for District patients. Those providers are listed on Attachment 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 the purpose of verifying income:

1. W-2 withholding statements for all employment for applications for 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 for the relevant time period;
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. Statements written 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 District may pursue other sources of funding, including Medicaid.
7. In the event that the patient is not able to provide any of the documentation described above, the District 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 District 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 the Federal Poverty Guidelines link below. The initial determination shall remain valid for 180 days. After that, the District may request updated information or re-verification of the patient's qualification status.

Income verification is required as outlined in the District's Financial Assistance Application form instructions. For elective services not covered please contact the respective clinic or hospital department.

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

Denials
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 District 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 seven (7) years.

PROCESS FOR COMMUNICATION
The District's Financial Assistance policy shall be publicly available in the following ways:
A. Financial agreement forms will state that financial responsibility is waived or reduced if the patient is determined eligible for Financial Assistance.
B. Signage indicating the District's participation in a Financial Assistance program shall be openly posted in public areas of the Hospital and Clinics.
C. The District will provide written notice of the District's Financial Assistance policy to patients upon request.
D. Both written information and verbal explanation shall be available in any language spoken by more than ten percent (10%) of the population in the District's service area. The District has identified Spanish language to be included in this context.
E. The Financial Assistance policy and summary, financial assistance application, billing information and patient financial services will be posted on the website for patients.
F. Financial assistance information, collections information and the District's methodology for calculating the Amounts Generally Billed is available by contacting our patient financial services at 360-642-6336, by email at https://www.oceanbeachhospital.com/patient-information/ or through My Chart at https://orca.myonlinechart.org/affiliate/Billing/Summary. You can also mail a request for assistance to Ocean Beach Health, PO Box H, Ilwaco, WA, 98624.

Sliding Scale Fee 2025

FINANCIAL ASSISTANCE SLIDING FEE SCALE 2025

AWARD	Federal Poverty Level (FPL)		100% Financial Assistance		75% Financial Assistance		50% Financial Assistance	
Family Size			Income from 100% FPL	Income To 200% FPL	Income From 201% FPL	Income To 250% FPL	Income From 251% FPL	Income To 300% FPL
1	FPL	15,650	0	31,300	31,301	39,125	39,126	46,950
2	FPL	21,150	0	42,300	42,301	52,875	52,876	63,450
3	FPL	26,650	0	53,300	53,301	66,625	66,626	79,950
4	FPL	32,150	0	64,300	64,301	80,375	80,376	96,450
5	FPL	37,650	0	75,300	75,301	94,125	94,126	112,950
6	FPL	43,150	0	86,300	86,301	107,875	107,876	129,450
7	FPL	48,650	0	97,300	97,301	121,625	121,626	145,950
8	FPL	54,150	0	108,300	108,301	135,375	135,376	162,450

For each additional person over 8 add $5500

The Federal Poverty Guideline Percentages can be found at:
https://aspe.hhs.gov/poverty/

Independent Providers Delivering Emergency or other Medically Necessary Services

The independent providers listed below deliver services at Ocean Beach Health, bill separately for their services, and are not subject to the District's Financial Assistance Policies. These providers do make independent financial assistance determinations.

Providence Health and Services: Provides tele-hospitalists services for inpatients and outpatient observation patients. Billing Inquiries: 866-747-2455, PO Box 3177, Portland, OR 97208-3177.
Financial Assistance: PO Box 4227, Portland, OR 97208-3395

Inland Imaging: 801 S Stevens St, Spokane, WA 99204. Website: https://www.inlandimaging.com/billing
Phone: (509) 891 - 0209

LabCorp: Website: https://www.labcorp.com/patients/bill-pay

NewGen ED physician group: NewGen Emergency Medicine
1006 N. Baylen St
Pensacola, FL 32501
850.287.2421
info@newgenem.com

PROCEDURE:

1. The law requires the facility to inform a patient about charity care anytime you ask them about insurance coverage, discuss how the patient or guarantor intends to pay, or anytime someone asks about financial help.
2. The hospital's goals are to:
    - Make patients aware of the availability of financial assistance.

- To successfully direct anyone inquiring about financial assistance or who says they can't pay or needs help paying for medical care to our financial assistance resources.
- Maintain clear documentation that patients have been offered information and screening.

3. If the patient/guarantor is in need of an interpreter, one will be provided at no cost.
4. When the patient presents to any registration setting (i.e. hospital, clinic, Wellness Center), the Healthcare Access Staff (HCA) will ask the patient/guarantor if they would like information on financial assistance (charity care). If they answer yes, the HCA staff will inquire as to the number of family members living in the household and approximate annual earnings.
5. The staff member will enter this information into Epic, regardless of their answer. If they meet eligibility requirements, a message will be generated in Epic to place the patient's record into a financial queue. The billing department will reach out to the patient/guarantor to start the financial assistance process.