



Blue Mountain Hospital District

170 Ford Road, John Day, Oregon 97845

FINANCIAL ASSISTANCE POLICY

Application for financial assistance shall be reviewed by hospital administration and the unit board of trustees. Approved financial assistance cases shall be distinguished from bad debts in the accounting records and financial statements of the hospital. Blue Mountain Hospital/Nursing Home, as a Public District, will not deny necessary care due to a patient's ability to pay. Financial assistance status for necessary services will be considered on a case-by-case basis when requested by the patient or upon review as described below:

The medical necessity of any particular patient's care will be subject to review by the hospital's Utilization Review Committee. If a patient receives services that are determined NOT medically necessary, those services will be excluded from financial assistance considerations.

Criteria used to determine medical indigence may include, but is not be limited, to the following:

- 1) Patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose gross income(s) equals 150% of the Federal Poverty Standards, adjusted for family size.
- 2) Net worth including all liquid and non-liquid assets owned, less liabilities and claims against assets.
- 3) Employment status along with future earning capacity, including the likelihood of future earnings sufficient to meet the obligation within a reasonable period of time.
- 4) Number of household family members.
- 5) Other financial obligations including living expenses and other items of a reasonable and necessary nature.
- 6) The amount(s) and frequency of the hospital bill(s) in relation to all of the factors outlined above. Those who meet the criteria will be considered to full or partial financial assistance awards, depending upon the patient's ability to pay a portion of the amount owed.

Accounts making irregular payments will be reviewed monthly and referred to collections when there is no evidence provided regarding qualifications for receiving financial assistance.

Slow paying accounts and those which have been turned to collections will be reviewed periodically and patients contacted to see if there have been changes in circumstances that would grant eligibility for financial assistance. Accounts in collections which are later determined to be indigent due to changing circumstances will be charity by the collection agency and referred to the hospital business office for follow up with the patient.

The aforementioned policy is not intended, nor should it be construed to guarantee free care to any particular person. It assures that Blue Mountain Hospital shall provide care without charge, or at a charge below cost, to those persons who meet the criteria.



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APPLICATION INFORMATION AND INSTRUCTIONS FOR FINANCIAL ASSISTANCE

Blue Mountain Hospital District agrees that necessary care provided in its facility will not be denied to any individual in need of care because of a person's inability to pay. Persons who qualify may receive hospital services at no charge or less than routine charge. Services provided to patients at no charge, or less than routine charge, are referred to as "Financial Assistance (Uncompensated or Partially Compensated Care)".

Financial Assistance does not include elective or cosmetic procedures and physician fees, other than emergency room physicians hired by the District. Also, not included are any services that are eligible for payment from any other source such as Department of Social and Health Services (Medicaid), Medicare or Insurance.

Applications for Financial Assistance are to be completed and signed by the patient (or the patient's guardian, if patient is unable to sign or is a dependent minor). Proof of income is to be provided and a copy retained with the application. All information given to Blue Mountain Hospital District will be considered CONFIDENTIAL.

ACCEPTABLE DOCUMENTATION:

(Any or all may be required)

IRS Tax Return

Payroll Check Stubs

Bank Statements

Dependent Birth Certificate(s)

Medicaid Rejection

Social Security Income Verification

Unemployment Compensation Determination

Rental Receipts (including subsidy information)

Statements of Accounts with Amounts Outstanding

Other Applicable Information, as required

Blue Mountain Hospital District may verify from listed references and credit reporting agencies any information given on the application. Verification is required for Blue Mountain Hospital District to show how it determined your income to receive credit for Financial Assistance. Copies of documentation will be retained with the application whether approved or denied.

The applicant will be notified of approval or denial for Financial Assistance within forty-five (45) working days after receipt of completed application and documentation. The applicant may be requested to furnish additional information or documentation before final determination is made.

DETERMINATION OF ABILITY TO PAY:

Family gross income below twice the federal poverty standard (see Exhibit A) will be used consistently as the principal criterion of medical indigence. The amount of charges credited to charity for eligible patients may vary based on individual family circumstances. If you qualify, your hospital bill may be reduced or forgiven. Patients will be held responsible to pay charges that are determined to be within their ability to pay based on this evaluation.

Exhibit A

To be eligible for financial assistance, your family income must be at or below the following levels:

SIZE OF FAMILY	YEARLY INCOME (NO CHARGE)	YEARLY INCOME (REDUCED CHARGE)
1	\$ 9,570	\$ 19,140
2	12,830	25,660
3	16,090	32,180
4	19,350	38,700
5	22,610	45,220
6	25,870	51,740
7	29,130	58,260
8	32,390	64,780
For Each Additional Family Member Add	3,260	6,520



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FINANCIAL ASSISTANCE APPLICATION

This financial statement is designed to assist in determining a reasonable payment plan for services rendered to you and/or your family. Please complete each inquiry on the statement and if an item does not apply to you, please respond by writing N/A in the corresponding blank. All information will be kept confidential. If you have any questions, please call (541) 575-1311.

Patient Account #: _____ Date: _____

Patient Name: _____ Spouse: _____

Mailing Address: _____

Physical Address (if different): _____

Home Phone: _____ Work Phone: _____

Employer: _____ Spouse's Employer: _____

Number in Household Adults: _____ Children & Ages: _____

HOUSEHOLD INCOME: Please provide the following information for each person, if applicable:

	Person 1	Person 2	Person 3
Gross Monthly Income (attach verification)	_____	_____	_____
Unemployment Benefits	_____	_____	_____
Length of Employment	_____	_____	_____
Social Security Benefits / Pensions	_____	_____	_____
Alimony / Child Support	_____	_____	_____
Stocks, Bonds, IRAs or Other Investments	_____	_____	_____
Government Assistance / Food Stamps	_____	_____	_____
Source of Other Income & Amount	_____	_____	_____

TOTAL INCOME: \$ _____

EXPENSES:

Rent/House Payments \$ _____	Power \$ _____	Telephone \$ _____
Healthcare Bills \$ _____	Hospital \$ _____	Medications \$ _____
Entertainment \$ _____	Childcare \$ _____	Health Insurance \$ _____
Other Insurance \$ _____	Credit Cards (total) \$ _____	
Alimony/Child Support \$ _____	Car Payments \$ _____	Groceries \$ _____
Auto Expense (Gas/License) \$ _____	Property Taxes \$ _____	
Other (Specify) \$ _____		

ASSETS:

Real Estate: House \$ _____ Location _____ Balance Owed: _____

Land \$ _____ Location _____ Balance Owed: _____

Vehicles: Year _____ Make _____

Year _____ Make _____

RV/Boat/Trailer: Year _____ Make _____

Checking Account: \$ _____ Bank _____

Savings Account: \$ _____ Bank _____

Certificates of Deposits: \$ _____ Bank _____

Cash Value of Life Insurance: \$ _____ Company: _____

I certify that this information is true and correct to the best of my knowledge:

Signature: _____ Date: _____

Signature: _____ Date: _____

I authorize Blue Mountain Hospital District (BMHD) to obtain such information as may be required (see instructions from acceptable verification) concerning the statements made in this application. I agree that the application shall remain the property of BMHD whether or not it is approved. I hereby certify that all statements made and the documentation furnished by me, are true and complete and are made for the purpose of obtaining financial assistance. I further agree to submit such additional or documentation (see instructions) that may be requested concerning my financial situation.

Signature Date