



<p>NORTHWEST POLICY: Medical Financial Assistance Policy</p> <p>APPROVED: Director, PBS: May 1, 2009 Director, Patient Registration and Pre-Service Director, Revenue Cycle: SOX: Director, Community Benefit: Chief Financial Officer:</p>	<p>POLICY #: PBS-FA-001 ISSUED: December 1, 2008 REVISED: May 1, 2009 NEXT REVIEW DATE: December 1, 2010 PAGE: 1 of 14</p>
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MEDICAL FINANCIAL ASSISTANCE POLICY (MFA)

1.0 Policy Statement

- 1.1 Kaiser Foundation Health Plan of the Northwest and Kaiser Foundation Hospitals (“Kaiser Permanente” or “Kaiser”) is committed to improving the health of all people in the communities where Kaiser facilities are located. This includes KP members and non-members.
- 1.2 Through the Community Benefit Program, Kaiser Permanente provides a range of programs to facilitate access to care for vulnerable populations. This includes offering medical financial assistance to uninsured and insured low income patients where ability to pay serves as a barrier to accessing medically necessary care.

2.0 Purpose

This set of policies and procedures govern application and administration of medical financial assistance for the patient’s financial obligation for medically necessary care.

3.0 Scope

- 3.1 This policy applies to Financially Qualified Patients receiving care. This includes medical services, products, and/or medications provided by Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Hospital, or the Northwest Permanente P.C., in all venues of care, for which a bill may be generated by KP, except as specified under Special Circumstances. It applies to all patient types, whether members or non-members of a Kaiser Foundation Health Plan, Inc. plan. The following business units/functions are impacted:
 - Kaiser Foundation Health Plan of the Northwest
 - Kaiser Foundation Hospitals
 - Northwest Permanente (NWP)
- 3.2 Kaiser utilizes a means-test designed to screen for and mitigate financial barriers to receiving medically necessary care for Financially Qualified Patients, regardless of current membership status.



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- 3.3 MFA / Discount awards may be applied to any medically necessary health care service provided by Kaiser hospitals, Kaiser physicians and providers and Kaiser pharmacies, for which a bill will be generated by Kaiser, except as specified under Special Circumstances.
- 3.4 The following services are not eligible for MFA, except as outlined under the Special Circumstances provision of this policy, and on a case-by-case basis:
 - 3.4.1 Non-emergency transport
 - 3.4.2 Skilled Nursing Care
 - 3.4.3 Optical and hearing aids
 - 3.4.4 Cosmetic services
 - 3.4.5 MFA may not be applied to specific pharmacy services, including:
 - 3.4.5.1 Over-the-counter drugs
 - 3.4.5.2 Non-formulary drugs unless a non-formulary exception has been granted
 - 3.4.5.3 Specifically excluded drugs, e.g., fertility, cosmetic, sexual dysfunction
- 3.5 An MFA award may apply to the interim period between the termination of a patient’s Medicaid coverage and the patient obtaining another source of payment.
- 3.6 Community charity care is considered out of scope for purposes of this policy. They are guided by Memorandum’s of Understanding (MOU) between Kaiser and Community organizations.

4.0 Definitions

- 4.1 **Assets.** Personal possessions of value, including cash, real estate, vehicles and investments.
- 4.2 **Catastrophic Event.** A life event such as loss of income, unusually high health care costs, death of a primary wage earner, or a disaster which results in a significant financial burden and creates a barrier to care. The event is evaluated by measurable criteria and meets designated financial thresholds.
- 4.3 **Community Benefit.** Programs and services that address community health needs and provide measurable improvement in health status, access or use of health care resources. These programs are planned, managed and organized to impact a community or a specific vulnerable population.
- 4.4 **Federal Poverty Guidelines (FPG).** Levels of annual income which establishes threshold for poverty as determined by the United States Department of Health



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and Human Services. The federal income guidelines are updated annually in the Federal Register. URL: <http://aspe.hhs.gov/poverty/07poverty.shtml>

- 4.5 **Financially Qualified Patients.** Patients who qualify for MFA by meeting the qualification criteria as described in the provisions of this policy determined by a Means Test.
- 4.6 **High Medical Costs.** Total out-of-pocket medical expenses incurred by the patient or the patient’s family in the past 12 months that exceed 10% of the patient’s family income. This may include costs incurred from other hospitals.
- 4.7 **Low Income, Insured.** An individual who does have health care insurance or other state or federal financial assistance but whose income is at or below 200% FPG.
- 4.8 **Low Income, Uninsured.** An individual who does not have any health care insurance or other financial assistance (federal or state) and whose income is at or below 400% FPG.
- 4.9 **Means Test(ing).** An evaluation of financial need based on income, Assets, and medical expenses, used to determine eligibility for MFA and or Pharmacy Waiver.
- 4.10 **Medically Necessary Care (medical necessity).** Generally, any care, treatment or services ordered by or provided by a licensed health care provider that are needed for the diagnosis or treatment of a medical condition and are not mainly for the convenience of the patient or medical care provider.
- 4.11 **Medical Financial Assistance (MFA).** Medical Financial Assistance is contingent on available funding. Medical Financial Assistance, also known as Charity Care, is a Kaiser charitable care program. MFA offers assistance to Financially Qualified Patients who are unable to pay for all or part of their medically necessary care and who have exhausted private and/or public medical coverage sources. Patients must meet financial criteria to receive a discount or an award that may cover some or all of the costs of care. MFA covers hospital-based services, medical office visits and pharmacy services (The Pharmacy Waiver program, part of MFA, covers Medicare Part D pharmacy services). Additional services may be covered under Special Circumstances. **Medical Financial Assistance is contingent on available funding.**
- 4.12 **Non-Member.** Individuals who do not have KP health insurance and who may be classified as self pay or have third party health care coverage.
- 4.13 **Patient’s Family.** Dependants that can be claimed on the patient’s Federal tax return only are to be included in family.
- 4.14 **Pharmacy Waiver Program.** Provides financial assistance to Kaiser Permanente patients who are unable to pay the cost share for outpatient prescription drugs. Patients eligible for either a full or partial MFA will receive a



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100% discount for the cost of all outpatient prescription drugs at pharmacies owned and operated by Kaiser Permanente. This waiver program applies to all outpatient pharmacy services only.

- 4.15 Supplemental Disability Income (SDI):** A program used by the Social Security Administration to pay benefits to people who cannot work because they have a medical condition that is expected to last at least one year or result in death.
- 4.16 Self-pay Patient.** A patient who does not have third-party coverage from a health insurer or a health care service plan, government or private, and whose injury is not compensable through workers' compensation, automobile insurance, or other insurance or settlements.
- 4.17 Special Circumstances.** Extraordinary circumstances, arising from a Catastrophic Event. Medical expense in relationship to the patient's income is considered. Special circumstances are evaluated anytime a patient identifies financial hardship. Eligibility for special circumstances is not limited by income or membership, and is available to patients with Kaiser's Deductible HMO plan, High Deductible Health Plans (HDHP), Kaiser's classic plan, self funded, Medicare Part D/LIS coverage needing additional assistance or other plan offered by Kaiser, as permitted or required by State or Federal law.
- 4.18 Supplemental Security Income (SSI):** The SSI program may provide monthly disability income for those who meet Social Security rules for disability and who have limited income and resources.
- 4.19 Durable Medical Equipment (DME):** DME as used in a patient's home and as prescribed by a Plan physician, in accordance with KP DME guidelines. Only DME intended for repeated use, to serve a medical purpose for a person who is injured or ill, will be considered.

5.0 Provisions

- 5.1 Eligibility.** Patients who are unable to pay for all or part of the cost of medically necessary care, and who may have exhausted private and / or public medical coverage sources may be eligible for MFA, Pharmacy Waiver or a discount payment plan.
 - 5.1.1** Prior to being considered for eligibility, patients are required to apply for all public and/or private coverage, such as Medicare and Medicaid for which they may be eligible. This includes the Low Income Subsidy available to Medicare Part D recipients. Patients shall be assisted as needed, in determining linkage to these programs, and in applying for such coverage.
 - 5.1.2** Patients will undergo Means Testing which will apply to all family members of the household to qualify for financial assistance. If the guarantor or subscriber within a family is approved for financial assistance, all dependants of the guarantor or subscriber are also deemed approved. If



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conditions exist where they do not qualify for other coverage income thresholds are as follows:

5.1.2.1 A full application process and means testing will apply to patient’s who fall between 201% and 400% of the FPG. Uninsured patients are eligible for partial financial assistance at 60% of charges and/or a pharmacy waiver (as prescribed under section 4.14 of this policy) for the duration for their award. Patients who fall between the 201% to 400% of the FPG and experience Special Circumstances may also be eligible for assistance for payments related to cost-sharing, such as co-payments, co-insurance and deductibles.

5.1.2.2 A full financial award will be applied for all patients meeting FPG at or below 200%.

5.1.2.3 No asset test is required for a patient whose income is less than or equal to 200% FPG.

5.1.3 Assets shall exclude a patient’s primary residence, automobile and any retirement accounts or deferred compensation.

5.1.4 Asset requirements shall not be stricter than those required by Medicaid. Any documentation that the patient has been approved for State programs will be automatically eligible for MFA under this policy.

5.1.5 Any patient who meets the Special Circumstances definition and financial criteria is eligible for assistance regardless of where they fit with the FPG and whether they may also qualify for other means of public assistance.

5.2 Asset Calculation: Items considered when calculating personal Assets include:

5.2.1 The first \$10,000 of a patient’s monetary Assets shall not be counted in determining eligibility.

5.2.2 Remaining monetary Assets shall be considered at 50% of their value.

5.2.3 The primary residence and automobiles, and any retirement or deferred compensation plans are excluded from the asset calculation.

5.2.4 Other assets may be included in the calculation, as deemed appropriate by Kaiser

5.3 Documentation. Patient’s must complete an application for financial assistance, and provide supporting documentation as outlined in the following table, categorized by FPG.



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FPG Range	A Pay Stub w/YTD	B 2 Current Pay stubs	C Current Tax Return	D SSI or SDI	E Other Income	F Asset Evaluation	G Medical Expenses
<= 200%	R	R*	R*	R*	NR	NR	NR
201% to 400%	R	R*	R*	R*	R	R	NR
> 400%	R	R*	R*	R*	R	NR	S

Legend:

- R Document is required for eligibility for MFA and / or Discount Programs
- R* If A is not available, then B, C, or D may be substituted, in successive order, for MFA and / or Discount Programs.
- NR Not required at this level of FPG for MFA or Discount Programs
- S Required for Special Circumstances eligibility at this level of FPG

- 5.3.1 Pay Stub w/YTD (A).** One current pay stub, if YTD information is included. (see 5.3.2)
- 5.3.2 2 Current Pay stubs (B).** If YTD information is NOT included, then copies of 2 subsequent and current pay stubs are required.
- 5.3.3 Current Tax Return (C).** If NO pay stubs are available, then copy of the most recent federal tax return. If tax forms are prepared by someone other than the patient, and / or has been submitted electronically, a SIGNED form is NOT required. If the patient has self-prepared, submitted copies must include the patient's signature.
- 5.3.4 EDD, SSI or SDI (D).** If pay stubs OR tax returns are not available, copies of other documents, such as letters from disability, social security or unemployment must be provided.
- 5.3.5 Other Income (E).** Documentation of all other income sources, including but not limited to income from rental property, alimony and / or child support payments, annuity income, etc.
- 5.3.6 Asset Evaluation (F).** (for full financial assistance awards only) requires documentation as follows:
 - 5.3.6.1.** One current bank statement for each of the following accounts, as applicable:
 - Savings Account(s)
 - Checking Account(s)
 - Statements of Certificates of Deposit



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- Statements for Money Market, Brokerage or other investment accounts
- If the patient does not have estate assets upon death, verification, and at the family's notification, the deceased will be awarded full financial assistance to any outstanding balance

5.3.7 Medical Expenses (G). All medical expenses, such as paid bills or receipts, including those rendered outside of Kaiser, may be used to determine these costs.

5.3.8 On a case-by-case basis, and outside of Special Circumstances, when none of the required is available, a patient may submit a signed attestation of their financial position.

5.3.9 For the purpose of documenting eligibility, electronic screening tools can be used in lieu of documentation from a patient.

5.4 A Special Circumstance, precipitated by a Catastrophic Event such as loss of income, unusually High Medical Costs, death of a primary wage earner, or other financial hardship, exists when an evaluation of the patient's financial situation demonstrates that 12 months of **incurred** medical expenses equals or exceeds 10% of annual income.

5.4.1 To patients at any level of FPG who meet income to medical expense criteria.

5.4.2 To any medically necessary medication when there are not generic alternatives available. All financial awards for pharmaceuticals will be at the 100% award level.

5.4.3 To non-formulary DME, limb prosthesis, implants or devices.

5.4.4 To an Unmet Medicaid Share of Cost (patient's portion).

5.4.5 To a patient's deductible and co-payment amount at time of service. Note: MFA awards do not accumulate to a patient's annual out of pocket maximums or lifetime limits.

5.5 Presumptive MFA Eligibility. When a patient experiences an adverse financial circumstance where providing eligibility documentation is not feasible, presumptive eligibility may be applicable. Patients are eligible to receive an MFA award under Special Circumstances criteria. Presumptive eligibility exists under the following conditions:

5.5.1 Homeless patient. For a patient to be qualified as homeless the following criteria must be met:



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5.5.1.1 The patient does not have a residence (such as *individuals who lack a fixed, regular, and adequate nighttime residence*). The patient’s situation (lack of a support system, sharing housing due to economic hardship or loss, inability to purchase supplies and prescriptions due to lack of funds or access to them etc.) can be assessed through a patient interview.

5.5.2 Catastrophic Event. If a patient has been involved in or affected by a national/regional Catastrophic Event which has left them without health care or insurance documentation they may be awarded MFA. The following criteria determine if the patient can qualify under presumptive eligibility:

5.5.2.1 The Catastrophic Event (e.g. hurricane) is generally well known and is qualified as a natural disaster by the state or federal government.

5.5.2.2 The Catastrophic Event has caused loss of or inability to inhabit their residence and an inability to have access to any financial records or health insurance information.

5.5.2.3 Patients are required to complete basic financial information and attest to its validity

5.5.2.4 Retrospectively, if health insurance information or other payment sources are identified, billing may occur. When this situation occurs the patient shall not be billed for the patient responsibility portion of the charges.

5.6 Award Duration. A patient may be approved for financial assistance for a specific duration of time, or for episodic care, as follows:

5.6.1 Specific Duration: Financial assistance, up to 6 months, for ongoing, medically necessary care, in an inpatient, outpatient, emergency or pharmacy setting.

5.6.2 Episodic: Financial assistance for a specific episode of care, or for a spell of illness related to a particular medical event.

5.6.3 Related Care: Financial assistance for specific services rendered just prior to, or immediately following an episodic medical event, which should be included in the episodic award.

5.6.4 Interim: Patients with linkage to a government program will be awarded an interim award of 3 months while their application is pending with the government agency.

5.6.5 Extensions to initial duration: Patients may request an extension to their initial MFA award. These conditions apply:



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5.6.5.1 Requests must be in writing, and must include a new application and documentation to demonstrate that there has been no material change to the income and Assets reported on the initial application.

5.6.5.2 On a case-by-case basis, and / or under Special Circumstances, award duration may exceed 6 months without requiring the patient to reapply.

5.6.5.2.1 Patients, whose financial position will not change, because they are on a perpetual limited income, may write a letter requesting an extension.

5.6.5.2.2 Applications delayed due to KP processes will be considered for an extension of 60 days to the award duration.

5.6.6 Effective Date: Awards commence from the date of service for which the award is being requested.

5.7 Outreach. The Medical Financial Assistance program allows flexibility to respond to local community needs, such as gaps in medical care or public programs. Outreach programs will be coordinated with local medical centers as specific community needs are identified and as deemed appropriate by Kaiser.

5.8 Payment Arrangements under the Discount Program: A patient approved for a discount may set up an extended payment plan, as outlined in the Patient Billing Services’ “Member/Non-Member Collections Policy”.

5.9 Patient Responsibility. Patients must make a reasonable effort to provide all requested and required documentation when applying for financial assistance. If a patient fails to provide information that is reasonable and necessary, Kaiser may consider that failure when making a determination of eligibility.

5.9.3 Required supporting documentation must be received by Patient Billing Services (“PBS”) no more than 30 days from date the application is received, or the case will be closed and a letter of denial will be issued. At that time, a patient must reapply if they wish to be considered for financial assistance.

5.10 Appeals: Patients have the right to appeal if a denial letter has been issued.

5.10.1 Denial letters will contain information about the appeal process.

5.10.2 Patients are responsible for initiating their appeal request. This is not an automatic process.



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5.10.3 When submitting an appeal, patients must provide additional or different information, or any corrections to the original application, to substantiate a valid reason for the appeal.

5.10.4 Appeal applications will be reviewed by a regional team, comprised of the Regional Director and / or a PBS Associate Director / Director, who is authorized to change the decision outcome. The decision making process may include area leadership on a case by case basis.

5.10.5 Appeal decisions will be communicated to the patient within 30 days of the completed appeal application.

5.11 Monitoring and Review of Performance: On a regular basis, the Regional Director shall monitor and review performance metrics, as established in compliance with the Board of Directors guidelines for charitable care investment, to ensure that Regional Community Benefit program objectives for MFA are being met. At a minimum, metrics will include:

5.11.1 YTD budgeted and actual award amounts

5.11.2 Application statistics, including the number of applications submitted, approved, pending and denied.

5.11.2.1 Denial reasons and related trends

5.11.3 Demographic information such as age and % of FPG for awards.

5.12 Communication / Signage and Financial Counseling. Information about the financial assistance programs available from KP shall be widely available to all patients seeking care, to all KP staff and providers who deliver services, and to all employees who may need to discuss patient financial responsibility.

5.12.1 Regular communication about Regional MFA Programs and the availability of financial counseling shall be provided as:

5.12.1.1 Information on the Regional website.

5.12.1.2 Signage in public areas which included public entrances to hospitals and medical office buildings, pharmacy, emergency and urgent care departments and all areas in hospital licensed space. Other additional locations may be identified by regions.

5.12.1.3 In the form of a printed Notice to Patient, provided to each patient receiving services in the hospital setting. Other additional locations may be identified by the region.

5.12.2 Communications about Regional MFA Programs shall be easy to understand, culturally appropriate, and in the prevalent languages in the applicable community.



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5.12.3 Financial Counseling services are available at select facilities and by phone.

In cases where a patient has applied, and been approved for a discounted payment, and where the patient has already made payments for those services approved under the application, the hospital will reimburse the patient any amount actually paid in excess of the amount due.

5.13 Collections. Regions shall retain collection agencies that will operate consistently with law and with KPHP/H’s reputation and charitable mission. Except in cases of fraud or other exceptional circumstances, all collections efforts shall comply with the following limitations and processes.

5.13.1 Bench warrants and foreclosures on patients’ primary residences are prohibited.

5.13.2 Legal action will not be pursued for non-payment of medical bills against any person who is unemployed and without other significant income.

5.13.3 Legal action will not be pursued when the only recovery available consists of a lien upon the patient’s primary residence.

5.13.3.1 Before taking legal action for non-payment of medical bills, financial counseling will be offered to determine whether the patient is eligible for any public assistance program or the Region’s MFA Program.

5.13.3.2 A low-income patient with unpaid medical bills will not be subject to lawsuits, wage garnishments and negative credit reports without prior approval by a designated Kaiser manager. The Kaiser manager designated for this role shall have a background appropriate for a position involving decisions that help define Kaiser’s position as a charitable institution.

5.13.3.3 The MFA Program shall expressly provide for a period of time prior to referral of a delinquent account to collections in which contacts and negotiations with the patient will be attempted. Additionally, the MFA Program shall specify minimum number and method of contacts required prior to referral to collections.

5.13.3.4 Kaiser shall maintain oversight of collection agency work and the right to recall collection activities for a given account. Additionally, Kaiser shall (a) instruct collection



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agencies that their goal is to collect from patients who are in a financial position to pay their medical bills and avoid driving low-income patients into bankruptcy as a result of their medical bills, and (b) amend their contracts with collection agencies to reflect the limitations stated in this policy.

5.13.3.5 When a case of fraud or exceptional circumstance occurs and deviates from 5.11.2 an exception approval must occur prior to initiating any action.

5.13.3.6 Prior to an account going to a collection agency, the account will be screened for Medical Financial Assistance qualification. If the patient falls below 200% of the FPG, full financial assistance will be awarded. For patients identified in the 201% - 400% FPG, financial counseling will be offered to determine whether the patient is eligible for any public assistance program or the Kaiser’s MFA Program.

6.1 TRAINING:

PBS and front line staff are trained on this policy, as applicable, and will follow applicable desk procedures. The “Policy Communications and Related PBS Manager/Supervisor Responsibility”, Policy No. PBS-RC-014, is also followed.

7.1 AUDIT PROCEDURE:

Audits of MFA Adjustments will be performed monthly by either the PBS Auditor, the Revenue Cycle Reporting & Internal Controls department, or designee. This person will be referred to below as “The Auditor”. This audit complies with **Revenue Cycle SOX control 07.09.06**.

Monthly, the Revenue Cycle Report and Systems Developer will deliver a Crystal Enterprise report to the Auditor listing all MFA approvals / denials for the previous month. The report will include both Professional Billing (PB) and Hospital Billing (HB) MFA transactions made in the KP HealthConnect application.

Monthly, the Auditor will audit the documentation supporting a judgmentally selected sample of MFA approvals / denials to ensure that each transaction is appropriate, properly documented and authorized. Specifically, the Auditor will review the MFA transaction to see if the following criteria were met:

1. Was Medical Financial Assistance (MFA) Application complete including necessary supporting documentation?
2. Was the MFA approval / denial appropriate based upon income / asset evaluation?



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3. Was MFA approval within Scope of User Authorization and are correct signatures present?
4. Was the MFA write-off posted in KPHC by the appropriate User?
5. Was MFA adjustment credited in KPHC correctly? (i.e. correct Guarantor, Patient, date of service)

The Auditor must complete the Monthly MFA Audit Report form and maintain records of this monthly process for a minimum of 2 years in keeping with the SOX Document Retention Guidelines. If any of the sampled transactions fail any of the 5 criteria, the Auditor must complete the **Action Plan** tab of the MFA Audit Form.

Monitoring results will be

- Reported monthly to the PBS Director.
- Maintained on file in keeping with the KPNW Document Retention Policy.
- Provided as feedback to the supervisor of the appropriate department.

8.1 CORRECTIVE ACTION PROCEDURE (CAP):

In the event that results from probe audits reveal material deficiencies or a pattern of deficiencies in applying the principles of this policy, PBS Director will:

- Report the issue to the Director of Revenue Cycle the Chief Financial Officer and the Director of Community Benefits.
- Prepare a corrective action plan (CAP) to effectively remediate the deficiency. CAP must be approved by the Director of PBS, Chief Financial Officer, and Chief Compliance Officer before implementation.

APPROVALS:

Signature on File in Medical Operations Business Services

Director, Patient Business Services **Date**

Signature on File in Medical Operations Business Services

Director, Community Benefit **Date**

Signature on File in Medical Operations Business Services

Director, Revenue Cycle **Date**

Signature on File in Medical Operations Business Services

Director, Patient Registration and Pre-Service Clearance **Date**



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Signature on File in Medical Operations Business Services

SOX

Date