

LOWER UMPQUA HOSPITAL

Financial Assistance Policies

POLICY:

- Hospital financial assistance policies will be consistent with recommended guidelines.
- Minimum assistance levels and sliding fee scales will be based on current Federal Poverty Guidelines published by the Centers for Medicare and Medicaid Services.
- Sliding fee scales allow situational exceptions for families above 150 percent of current Federal Poverty Guidelines.
- A common application process will be available for all hospital services.
- Written materials explaining the financial assistance programs in appropriate languages for the community will be readily available at registration sites.
- Continuing education and communication of financial assistance guidelines to employees will be implemented and monitored by hospitals.
- Final determination and qualification for financial assistance may vary from hospital to hospital, based on each hospital's individual guidelines.

To this end, we establish the following:

Financial Assistance Guidelines

1. Financial assistance is available to all families below 150 percent of current Federal Poverty Guidelines (FPG).
2. A sliding fee scale and situational consideration is available when family income exceeds 150 percent of FPG.
3. The sliding fee scale will be updated annually in conjunction with the FPG updates published by the Centers for Medicare and Medicaid Services in February or March of each year.

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4. The hospital's financial assistance application and approval process is the same regardless of service provided or amount of the bill.
5. Before any collection agency assignment, a patient's history shall be reviewed to confirm whether a financial assistance determination was previously made.
6. Patients may re-apply for financial assistance before, during, or after care or after collection agency assignment if their situations change.
7. Financial Assistance Applications and Business cards notifying patients of financial assistance programs and where to telephone for assistance shall be located in appropriate locations throughout the hospital
8. Signage notifying people of financial assistance programs shall be posted in public locations in the hospital. The signs shall provide the telephone number and the location of information about available financial assistance.
9. Brochures outlining the financial assistance application process shall be available at patient registration desks and in waiting areas.
10. Hospital employees should know how to refer a patient or family to the appropriate location in the hospital for financial assistance information.
11. All employees in patient accounting and registration areas should understand the hospital financial assistance policy, have access to the application forms, and be able to direct questions to the proper hospital representative.
12. The CFO shall cause staff financial assistance awareness and education to be evaluated by monitoring the ability of the public to obtain information in a timely manner about available resources.

Financial Assistance Screening

Request for financial assistance may be made at any point before, during, or after the provision of care. The hospital will use an application process for determining initial interest in and qualification for financial assistance. A responsible party choosing not to apply for financial assistance will not automatically be considered for assistance. The hospital's decision to provide financial assistance in no way affects the responsible party's financial obligations to their physician or other health care provider. Requests for financial consideration may be proposed by sources such as physicians, community or religious groups, social services, hospital personnel, the patient, responsible party, or family member. Financial assistance is specific to each admission of the patient. New or re-admission will be screened for changes in eligibility for financial assistance.

Financial assistance is granted for medically necessary procedures only.

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A business office representative should be consulted in special situations. Financial assistance is secondary to all other financial resources available to the patient including insurance, government programs, third-party liability, and assets. Lower Umpqua Hospital assists persons with financial need by waiving all or part of the charges for services provided by Lower Umpqua Hospital. The following are general guidelines; however, each individual situation will be reviewed independently. Allowances may be made for extenuating circumstances.

Financial Assistance General Operating Policy

Subject: Financial Assistance/Services

I. OBJECTIVE

To ensure that Lower Umpqua Hospital meets its community obligations to provide financial assistance in a fair, consistent and objective manner.

II. POLICY STATEMENT

A. It is both the philosophy and practice of Lower Umpqua Hospital that medically necessary healthcare services should be available to all individuals, regardless of their ability to pay.

B. Lower Umpqua Hospital assists persons with financial need by waiving all or part of the charges for services provided by Lower Umpqua Hospital.

III. PROCEDURE

A. Eligibility Criteria

1. Business Office personnel are available to help patients identify financial options or assistance programs.
2. All collection efforts shall cease while the determination of eligibility for financial assistance is being determined.
3. Financial assistance is generally secondary to all other financial resources available to the patient, including insurance, government programs, third-party liability and assets.
4. Full financial assistance usually will be provided to a responsible party with gross family income at or below 150 percent of Federal Poverty Guidelines.
5. A sliding-fee scale will be used to determine financial assistance discounts when gross family income is above 150 percent of Federal Poverty Guidelines.

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6. A sliding-fee scale will be used to determine financial assistance discounts when gross family income is above 150 percent of Federal Poverty Guidelines.
 7. Notification of financial assistance determinations will be mailed to the responsible party. Reasonable payment arrangements consistent with the responsible party's ability to pay will be extended for amounts owed.
- B. Eligibility Determinations
1. The provision of medically necessary healthcare shall never be delayed pending an assistance determination.
 2. Requests for financial assistance may be made at any point before, during or after the provision of care.
 3. Financial assistance requests may be proposed by sources other than the patient, such as the patient's physician, family members, community or religious groups, social services, or hospital personnel.
 4. Anyone wishing to make application for financial assistance with Lower Umpqua Hospital will be given a Financial Assistance Application, which includes instructions on how to apply.
 5. Consideration for financial assistance will occur once the applicant supplies a completed Financial Assistance Application with supporting documents to the Lower Umpqua Hospital Business Office.
 6. Lower Umpqua Hospital will make every attempt to make assistance determinations within 20 days of receiving a completed Financial Assistance Application.
 7. Consideration for assistance includes a review of the responsible party's annual household income, number of people in the home, assets, credit history, existing debt and other indicators of the party's ability to pay. These are merely guidelines; each individual situation shall be reviewed independently. Allowances may be made for extenuating circumstances.
 8. Consideration for assistance includes a review of the responsible party's annual household income, number of people in the home, assets, credit history, existing debt and other indicators of the party's ability to pay. These are merely guidelines; each individual situation shall be reviewed independently. Allowances may be made for extenuating circumstances.

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9. Acceptable verification of income includes the following: the most current 90 days' worth of payroll stubs; a copy of the most current year's IRS tax return; verification of Social Security or unemployment benefits. In the absence of income, a letter of support from individuals providing for the patient's basic living needs is required.
 10. Lower Umpqua Hospital will keep all applications and supporting documentation confidential. Lower Umpqua Hospital may, at its own expense, request a credit report to further verify the information on the application. Incomplete applications may be denied and returned with a statement of what information is needed and how to re-apply.
 11. Financial assistance may be denied if application is not completed and returned to Lower Umpqua Hospital within **20 days** of request.
 12. Financial assistance will not be considered without a completed Financial Assistance Application *unless* sufficient like information can be obtained that allows for a final determination without an application. In extenuating circumstances, where it can support a financial hardship exists, Lower Umpqua Hospital may offer financial assistance at its own determination.
 13. Financial assistance is not granted for some procedures, such as elective cosmetic surgery or some special situations, such as that of an individual who is eligible for insurance but has refused to apply. Business Office personnel should be consulted in these special situations.
- C. Appeals

The responsible party may appeal a financial assistance determination by providing additional information, such as income verification or an explanation of extenuating circumstances, to the Business Office director within 30 days of receiving notification. The Business Office director will review all appeals. The responsible party will be notified of the appeals outcome. Collection follow-up on accounts will be pended during the appeal process.

FINANCIAL ASSISTANCE APPLICATION

To apply for Financial Assistance at Lower Umpqua Hospital:

1. Complete this application.
2. Attached copies of: Previous year's tax returns AND verification showing year to date income or last 3 months pay stubs.
3. Submit to Hospital Business Office

GENERAL INFORMATION

Patient's name	Last	First	M.I.	Social Security Number	Date of birth
<input type="checkbox"/> Yes <input type="checkbox"/> No					
U.S. Citizen	Marital status	Spouse's name		Last	First
		M.I.	Telephone No.		Home / Work
Person responsible for paying the bill			Relationship to patient		Telephone No. Home / Work
Number of people in household			Ages of people in household		
Health insurance coverage (company name, ID#)					

MONTHLY HOUSEHOLD INCOME

	PERSON 1	PERSON 2	PERSON 3
NAME:	_____	_____	_____
RELATIONSHIP TO PATIENT:	_____	_____	_____
Monthly gross income (attach verification)	\$ _____	\$ _____	\$ _____
Unemployment, if so, how long _____	\$ _____	\$ _____	\$ _____
Social Security, pensions	\$ _____	\$ _____	\$ _____
Alimony/child support	\$ _____	\$ _____	\$ _____
Government assistance, food stamps	\$ _____	\$ _____	\$ _____
Other sources of income	\$ _____	\$ _____	\$ _____
Checking account balances	\$ _____	\$ _____	\$ _____
Savings account balances	\$ _____	\$ _____	\$ _____
Stocks, bonds, IRA's, investments	\$ _____	\$ _____	\$ _____
Other assets	\$ _____	\$ _____	\$ _____

NOTE: In the absence of income, a letter of support from individuals providing for the patient's basic living needs **is required.**

MONTHLY EXPENSES / BILLS

<input type="checkbox"/> Rent \$ _____	<input type="checkbox"/> Monthly Mortgage \$ _____	Mortgage Balance \$ _____	Equity \$ _____
Utilities	\$ _____	Alimony/Child support	\$ _____
Credit cards (total)	\$ _____	Health insurance	\$ _____
Insurance (vehicle/life/property)	\$ _____	Healthcare bills	\$ _____
Child care	\$ _____	Medications	\$ _____
Living, i.e. gas, food, clothes	\$ _____	Entertainment	\$ _____
Car (Include Make/Year)	\$ _____	Other	\$ _____

EXTENUATING CIRCUMSTANCES: Attach a separate page explaining any extenuating situation that you would like us to consider in making our determination

X _____ Date _____
Responsible Person's Signature (Required)

I certify the information contained above is correct and complete to the best of my knowledge, and may be verified by hospital. I hereby grant the Hospital permission to review my credit report for the purpose of verifying information I have provided.