

TITLE: FINANCIAL ASSISTANCE / UNINSURED DISCOUNT POLICY

POLICY OBJECTIVE

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

POLICY STATEMENT

- I. It is both the philosophy and practice of Tuality Healthcare that medically necessary health care services should be available to all individuals, regardless of their ability to pay.
- II. Based on eligibility, Tuality Healthcare assists persons with financial need by providing discounts or by waiving all or part of the charges for services provided by Tuality Healthcare.
- III. The provision of health care services should never be delayed pending an assistance eligibility determination.

PROCEDURE

I. ELIGIBILITY CRITERIA

- A. Financial counselors and Business Office personnel are available by phone at 503-681-1000 to help patients identify appropriate financial options or assistance programs.
- B. Financial assistance is generally secondary to all other financial resources available to the patient, including insurance, government programs, third-party liability, and assets.
- C. Full financial assistance usually will be provided to a responsible party with gross family income at or below 200% of Federal Poverty Guidelines (FPG). A sliding discount will be provided up to 400% of FPG.
- D. 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.

II. ELIGIBILITY DETERMINATIONS

- A. Requests for financial assistance may be made at any point before, during, or after the provision of care.

- B. 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.
- C. Anyone wishing to make application for financial assistance with Tuality Healthcare will be given a Financial Assistance Application, which includes instructions on how to apply.
- D. Consideration for financial assistance will occur once the applicant supplies a completed Financial Assistance Application with supporting documents to the Tuality Healthcare Business Office.
- E. Tuality Healthcare will make every attempt to make assistance determinations within 20 days of receiving a completed Financial Assistance Application.
- F. 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 should be reviewed independently. Allowances may be made for extenuating circumstances.*
- G. 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 will be accepted.
- H. Tuality Healthcare will keep all applications and supporting documentation confidential. Tuality Healthcare may, at its own expense, request a credit report to further verify the information on the application. .
- I. Financial assistance may be denied if application is not completed and returned to Tuality Healthcare within 20 days of receipt by the responsible party.
- J. 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 otherwise identify that a financial hardship exists; Tuality Healthcare may offer financial assistance at its own determination.
- K. Financial assistance is not granted for some procedures, such as elective cosmetic surgery or some special situations, including an instance of when an individual who is eligible for insurance but has refused to apply. A Business Office financial counselor should be consulted in these special situations.

III. APPEALS

Responsible parties 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.

IV. DISCOUNTS FOR UNINSURED PATIENTS

- A. Tuality provides discounted charges to patients who do not have health insurance coverage. This discount lowers the amount owed by 10 to 50 percent based on the patients account balance.
- B. The discount scale was established by calculating the average commercial insurance contract rate with Tuality Healthcare.

Attachments:

- A. Patient Accounting Financial Assistance Form, English (56-0178-6)
- B. Patient Accounting Financial Assistance Form, Spanish (56-0179-4)
- C. Physicians' Billing Office Financial Assistance Form, English (56-0185-1)
- D. Physicians' Billing Office Financial Assistance Form, Spanish (56-0187-7)
- E. Sliding Fee Schedule

Administrator/COO

Chief Financial Officer

Director, Medical Office Services

Director, Patient Administration Support

Formulated:	May, 2001
Reviewed:	
Revised:	March, 2004 October, 2004 March, 2005 May, 2006

	<p>Tuality Healthcare</p> <p><i>Please answer the questions below as complete as possible. All information will be kept confidential. If you have any questions please call 503-681-1000 Monday thru Friday 8:00 am - 5:00 pm</i></p>	<p>Return By _____</p>	<p>Acct# _____</p>
<p>Patient's Account(s) #: _____</p>			

FINANCIAL ASSISTANCE / SERVICES

Applicant Information

Patient's Name: Last		First		M.I.	U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Birth:	Social Security No.:	Marital Status:		Home Phone No.:	
Name of Person(s) Responsible For Patient's Account(s): Last		First		M.I.	
Current Address (City, State & Zip):					
Home Phone No.:	Social Security No.:		How Long Unemployed:		
Spouse Name: Last	First	M.I.	Home Phone No.:	Social Security No.:	
Current Address (City State & Zip):					
No. of Dependent(s) (self included):			Age(s) of child(ren) in household:		

Employment Information

Current Employer:	Phone No.:
Address (City, State, Zip):	
Current Employer:	Phone No.:
Address (City, State, Zip):	

Bank Account(s) Information

Checking No.	Balance:	Savings No.:	Balance:
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Monthly Household Income Information

	Responsible person: \$ x 12 mo =	Spouse: \$ x 12 mo =	Other: \$
Gross Income:	\$	\$	\$
Unemployment benefits:	\$	\$	\$
Social Security / Pension(s) Benefits:	\$	\$	\$
Alimony:	\$	\$	\$
Child Support:	\$	\$	\$
Gov't Assist. / Food Stamps:	\$	\$	\$
Other Source(s) of additional income:	\$	\$	\$

Other Monthly Expenses

	\$	\$	\$
Rent or Mortgage Payment:	\$	\$	\$
Utilities: (Water, Gas, Elect., Phone, Cable, Garbage)	\$	\$	\$
Health Insurance:	\$	\$	\$
Auto Insurance:	\$	\$	\$
Doctor Bill(s):	\$	\$	\$
Hospital Bill(s):	\$	\$	\$
Medication(s) / Prescription(s):	\$	\$	\$
Credit Cards(s) Payment(s):	\$	\$	\$
Auto Loan Payment(s)	\$	\$	\$
Other Loan(s), Debt(s), or Financial Obligations:	\$	\$	\$

Miscellaneous

BEFORE YOU RETURN APPLICATION, PLEASE CHECK THAT YOU HAVE PROVIDED THE FOLLOWING COPIES:

▶ Previous year State & Federal Income Tax return(s) with W-2 form(s)	▶ Income verification showing YTD earnings and/or paystubs for the last three months
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I hereby certify the information contained in the above financial questionnaire is accurate and complete to the best of my knowledge and authorize Tuality Healthcare to verify the information provided on this application.

Responsible person's signature: _____ Date: _____

Responsible person's signature: _____ Date: _____

Approved: _____ **Not Approved:** _____

**Tuality Healthcare****Regrese Antes De _____**

Por favor conteste a las preguntas abajo lo mas completo posible. Toda la información será mantenida confidencial. Si usted tiene Si usted Si tiene cualquier pregunta, llame al (503) 681-1000 de Lunes a Viernes de las 8:00 am hasta las 5:00 pm.

FINANCIAL ASSISTANCE / SERVICES - Spanish

Información del Aplicante

Nombre del Paciente : Apellido		Nombre		Inicial	¿Ciudadano de EE UU?: <input type="checkbox"/> Sí <input type="checkbox"/> No
Fecha de Nacimiento: (Mes / Día / Año)	No. de Seguro Social:	Estado Civil:		No. de Teléfono:	
Nombre de la Persona(s) Responsable de Pagar la Cuenta(s) del Paciente: Apellido			Nombre	Inicial	
Dirección (Ciudad, Estado y Código Postal):					
No. de Teléfono:	No. de Seguro Social:			¿Cuánto Tiempo Tiene Sin Trabajar?:	
Nombre de Esposo(a): Apellido		Nombre	Inicial	No. de Teléfono:	No. de Seguro Social:
Dirección (Ciudad, Estado y Código Postal):					
¿Cuánto(s) Dependiente(s) en Su Familia (Incluyendo Usted.)?:			Edad de Su Niño(s):		

Información de Empleo

Nombre de Empresa:	No. de Teléfono:
Dirección (Ciudad, Estado y Código Postal):	
Nombre de Empresa:	No. de Teléfono:
Dirección (Ciudad, Estado y Código Postal):	

Información de Cuenta(s) Bancarias

Cheques: \$	Ahorros: \$
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Información de Ingreso(s) Mensual Para Cada Familiar

	Persona Responsable: \$ x 12 meses =	Esposo/a: \$ x 12 Meses =	Otro: \$
Ingresos Total:	\$	\$	\$
Beneficios de Desempleo:	\$	\$	\$
Beneficios de Seguro Social/Pensiones:	\$	\$	\$
Pensión (por divorcio o separación)	\$	\$	\$
Manutención de hijos o de esposo	\$	\$	\$
Asistencia de Gobierno/Estampillas de Comida:	\$	\$	\$
Otros Ingresos Adicionales :	\$	\$	\$

Otros Gastos Mensual

Pago de Renta o Casa:	\$	\$	\$
Utilidades: (Luz, Agua, Basura, Gas, Teléfono, Cable)	\$	\$	\$
Seguro Médico:	\$	\$	\$
Seguro de Auto:	\$	\$	\$
Cuenta(s) de Doctor:	\$	\$	\$
Cuenta(s) de Hospital:	\$	\$	\$
Medicinas/Receta(s) del Doctor:	\$	\$	\$
Pago(s) de Tarjetas de Crédito:	\$	\$	\$
Pago de Carro(s)	\$	\$	\$
Otros Préstamos, Deudas, y/o Obligaciones Financieras:	\$	\$	\$

Información General

ANTES DE QUE USTED ENVÍE LA APLICACIÓN, COMPRUEBE POR FAVOR QUE USTED HAYA PROPORCIONADO LOS PUNTOS SIGUIENTES:

► **Declaración de impuestos del año anterior para el Estado y Federal con su forma W-2.**


► **Verificación de Ingresos de todo el año, hasta la fecha y/o Comprobante de Ingresos de los últimos tres meses.**


Certifico por este medio que la información contenida en el cuestionario financiero es correcta y completa al mejor de mi conocimiento y autorizo al hospital de Tuality Healthcare para verificar la información proporcionada para este uso.

Firma de la Persona Responsable: _____ Fecha: _____

Firma de la Persona Responsable: _____ Fecha: _____

Approved: _____ Not Approved: _____

 TCH - Physician's Billing Office Return By _____ Please answer the questions below as complete as possible. All information will be kept confidential. If you have any questions please call 503-681-5680 Monday thru Friday 8:00 am - 5:00 pm		Acct# _____ Patient's Account(s) #: _____		
FINANCIAL ASSISTANCE / SERVICES				
Applicant Information				
Patient's Name: Last		First	M.I.	U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Birth:	Social Security No.:	Marital Status:	Home Phone No.:	
Name of Person(s) Responsible For Patient's Account(s): Last		First	M.I.	
Current Address (City, State & Zip):				
Home Phone No.:	Social Security No.:	How Long Unemployed:		
Spouse Name: Last	First	M.I.	Home Phone No.:	Social Security No.:
Current Address (City State & Zip):				
No. of Dependent(s) (self included):		Age(s) of child(ren) in household:		
Employment Information				
Current Employer:			Phone No.:	
Address (City, State, Zip):				
Current Employer:			Phone No.:	
Address (City, State, Zip):				
Bank Account(s) Information				
Checking No.	Balance:	Savings No.:	Balance:	
Monthly Household Income Information				
	Responsible person: \$ x 12 mo =	Spouse: \$ x 12 mo =	Other: \$	
Gross Income:	\$	\$	\$	
Unemployment benefits:	\$	\$	\$	
Social Security / Pension(s) Benefits:	\$	\$	\$	
Alimony:	\$	\$	\$	
Child Support:	\$	\$	\$	
Gov't Assist. / Food Stamps:	\$	\$	\$	
Other Source(s) of additional income:	\$	\$	\$	
Other Monthly Expenses				
Rent or Mortgage Payment:	\$	\$	\$	
Utilities: (Water, Gas, Elect., Phone, Cable, Garbage)	\$	\$	\$	
Health Insurance:	\$	\$	\$	
Auto Insurance:	\$	\$	\$	
Doctor Bill(s):	\$	\$	\$	
Hospital Bill(s):	\$	\$	\$	
Medication(s) / Prescription(s):	\$	\$	\$	
Credit Cards(s) Payment(s):	\$	\$	\$	
Auto Loan Payment(s)	\$	\$	\$	
Other Loan(s), Debt(s), or Financial Obligations:	\$	\$	\$	
Miscellaneous				
BEFORE YOU RETURN APPLICATION, PLEASE CHECK THAT YOU HAVE PROVIDED THE FOLLOWING COPIES:				
▶ Previous year State & Federal Income Tax return(s) with W-2 form(s)		▶ Income verification showing YTD earnings and/or paystubs for the last three months		
I hereby certify the information contained in the above financial questionnaire is accurate and complete to the best of my knowledge and authorize Tuality Healthcare to verify the information provided on this application.				
Responsible person's signature: _____			Date: _____	
Responsible person's signature: _____			Date: _____	
Approved: _____		Not Approved: _____		

 TCH - Physician's Billing Office Regrese Antes De _____		Acct# _____		Patient's Account(s) #: _____	
Por favor conteste a las preguntas abajo lo mas completo posible. Toda la información será mantenida confidencial. Si usted tiene Si usted Si tiene cualquier pregunta, llame al (503) 681-5680 de Lunes a Viernes de las 8:00 am hasta las 5:00 pm.					
FINANCIAL ASSISTANCE / SERVICES - Spanish					
Información del Aplicante					
Nombre del Paciente : Apellido		Nombre		Inicial	
				¿Ciudadano de EE UU?: <input type="checkbox"/> Sí <input type="checkbox"/> No	
Fecha de Nacimiento: (Mes / Día / Año)		No. de Seguro Social:		Estado Civil:	
				No. de Teléfono:	
Nombre de la Persona(s) Responsable de Pagar la Cuenta(s) del Paciente: Apellido		Nombre		Inicial	
Dirección (Ciudad, Estado y Código Postal):					
No. de Teléfono:		No. de Seguro Social:		¿Cuánto Tiempo Tiene Sin Trabajar?:	
Nombre de Esposo(a): Apellido		Nombre		Inicial	
		No. de Teléfono:		No. de Seguro Social:	
Dirección (Ciudad, Estado y Código Postal):					
¿Cuánto(s) Dependiente(s) en Su Familia (Incluyendo Usted.)?:		Edad de Su Niño(s):			
Información de Empleo					
Nombre de Empresa:				No. de Teléfono:	
Dirección (Ciudad, Estado y Código Postal):					
Nombre de Empresa:				No. de Teléfono:	
Dirección (Ciudad, Estado y Código Postal):					
Información de Cuenta(s) Bancarias					
Cheques: \$			Ahorros: \$		
Información de Ingreso(s) Mensual Para Cada Familiar					
	Persona Responsable:		Esposo/a:		Otro:
	\$ x 12 meses =		\$ x 12 Meses =		\$
Ingresos Total:	\$		\$		\$
Beneficios de Desempleo:	\$		\$		\$
Beneficios de Seguro Social/Pensiones:	\$		\$		\$
Pensión (por divorcio o separación)	\$		\$		\$
Manutención de hijos o de esposo	\$		\$		\$
Asistencia de Gobierno/Estampillas de Comida:	\$		\$		\$
Otros Ingresos Adicionales :	\$		\$		\$
Otros Gastos Mensual					
Pago de Renta o Casa:	\$		\$		\$
Utilidades: (Luz, Agua, Basura, Gas, Teléfono, Cable)	\$		\$		\$
Seguro Médico:	\$		\$		\$
Seguro de Auto:	\$		\$		\$
Cuenta(s) de Doctor:	\$		\$		\$
Cuenta(s) de Hospital:	\$		\$		\$
Medicinas/Receta(s) del Doctor:	\$		\$		\$
Pago(s) de Tarjetas de Crédito:	\$		\$		\$
Pago de Carro(s)	\$		\$		\$
Otros Préstamos, Deudas, y/o Obligaciones Financieras:	\$		\$		\$
Información General					
ANTES DE QUE USTED ENVÍE LA APLICACIÓN, COMPRUEBE POR FAVOR QUE USTED HAYA PROPORCIONADO LOS PUNTOS SIGUIENTES:					
▶ Declaración de impuestos del año anterior para el Estado y Federal con su forma W-2.			▶ Verificación de Ingresos de todo el año, hasta la fecha y/o Comprobante de Ingresos de los últimos tres meses.		
Certifico por este medio que la información contenida en el cuestionario financiero es correcta y completa al mejor de mi conocimiento y autorizo al hospital de Tuality Healthcare para verificar la información proporcionada para este uso.					
Firma de la Persona Responsable: _____			Fecha: _____		
Firma de la Persona Responsable: _____			Fecha: _____		
Approved: _____			Not Approved: _____		

Attachment E

Sliding Fee Schedule

Income as a Percentage of Federal Poverty Level	Financial Assistance Adjustment Percent
0-219%	100%
220-239%	90%
240-259%	80%
260-279%	70%
280-299%	60%
300-319%	50%
320-339%	40%
340-359%	30%
360-379%	20%
380-399%	10%
400%	5%