PURPOSE

To provide financial assistance to uninsured and underinsured Southern Coos Health District patients in a fair, consistent, and objective manner.

POLICY

Southern Coos Health District (SCHD) assists persons with demonstrated financial need by waiving a portion or all of the charges for services provided by Southern Coos Hospital, for those persons who apply and qualify for financial assistance.

ELIGIBILITY CRITERIA and GUIDELINES:

Financial assistance will be considered based on submission of a completed Financial Assistance Application (with the exception for OHP/Medicaid recipients as listed below). In addition, for those who don't qualify for financial assistance or who qualify for a lower level of assistance, SCHD reserves the right to grant additional financial assistance based on extenuating circumstances and/or based on it' own determination.

1. Anyone wishing to apply for financial assistance with SCHD will be given a Financial Assistance Application, which includes instructions on how to apply.
2. Responsible parties with gross family income below 200% of the Federal Poverty Guidelines may be eligible for a prorated amount of financial assistance ranging up to a 100% discount (See worksheet).
3. Requests for financial assistance may be made at any point with the exception of accounts that have been at the collections agency past 30 days.
4. Consideration for financial assistance will occur with the exception of Medicaid/OHP recipients once the applicant supplies a completed Financial Assistance Application with supporting documents to the Billing Office.
5. The provisions of urgent/emergent healthcare are never to be delayed pending an assistance determination.
6. Financial assistance will be extended to qualified recipients without a completed financial application for visits where Medicaid/OHP insurance denies payment or pays the standard benefit.
7. Financial assistance may be denied if application is not completed and returned to the Billing Office within 30 days of receipt by the responsible party.
8. Consideration for assistance includes a review of the responsible party's annual household income, number of people in the home, assets, living expenses, existing debt, existing medical debt, and discretionary debt.
9. If unable to determine income due to self-employment, seasonal work, etc. the previous years' tax return may be used for eligibility.
10. SCHD will make every attempt to make assistance determinations within 30 days of receiving a completed Financial Assistance Application.

11. 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.

12. SCHD will keep all applications and supporting documentation confidential. Incomplete applications may be denied and returned with a statement of what information is needed and how to re-apply.

13. Financial assistance applications must be updated at least every 6 months when services continue to be rendered. Financial assistance requests for new services within the 6 month period from approval will be considered without requiring another application. EXCEPTION – Whenever there has been a meaningful improvement in income or assets, applicants are required to immediately update their Financial Assistance Applications. Failure to do so can result in denial of current or future financial assistance.

14. SCHD Financial Assistance is intended to aid the residents of the SCHD service area. To be considered a resident, the patient must have resided within the service area for at least six months preceding the date when services were rendered. The requirement of six months' residence shall not apply to individuals who reside outside the service area, but who require emergency treatment while traveling or visiting within the primary service area.

15. Brochures outlining the financial assistance application process shall be available in the lobby of the hospital and at the Patient Financial Services office.

INCOME:
Acceptable verification of income includes but is not limited to 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 describing support from individuals providing for the patients basic living needs will be accepted.

ASSETS:
All assets will be reviewed to determine what excess property may exist as allowed by the State of Oregon for Medicaid/OHP eligibility. Excess property may include: real estate other than primary residence, savings accounts or accessible balances in "investment" type accounts, retirement assets, trust funds, security interest, multiple vehicles, recreational vehicles and other assets.

EXISTING MEDICAL DEBT:
Existing medical bills may be considered on a case by case basis.

DISCRETIONARY DEBT:
Examples include: Auto loans, RV loans, department store or other revolving accounts, credit card debt. Loans/debt will be subject to a reasonableness threshold – the amount above the threshold is considered discretionary debt and only used to determine an ability to pay for payment arrangements.

LIVING EXPENSES:

Living expenses including food, clothing, housing (mortgage or rent), automobile expenses, insurance, and child support may be considered on a case by case basis. Living expenses are subject to a financial reasonableness threshold consistent with that allowed by the State of Oregon for Medicaid eligibility determination – the amount above the threshold is considered discretionary.

LIMITATIONS AND DISQUALIFICATIONS:

1. For patients who are insured and meet the financial assistance eligibility, the amount of assistance is limited to only the amount due after all insurance and any other available payments have been applied.
2. Financial assistance is not granted for some procedures, including all elective surgeries. Procedures determined to be non-covered could be considered for assistance at the discretion of Hospital. This would include non-emergency services received in the emergency room, elective cosmetic surgery or other procedures.
3. Financial assistance may be limited or denied based upon an individual's future ability to pay; i.e. when their lack of income is temporary, usually due to temporary lapse in employment.
4. Extension of payment arrangements for remaining balances due from the applicant may be granted to an individual for extended periods of time in order to allow the individual time to financially recover. Interest will be waived during this period of time.
5. Financial Assistance is not available to any individual who is eligible for insurance (including Medicare, Medicaid, Workers Comp, and Disability) but has refused to apply, or due to failure to appeal a denial of payment from an insurance or third party payer when there were reasonable grounds for appeal.
6. Financial assistance will be denied for providing fraudulent information, hiding income or assets, or failure to notify us of any meaningful improvement in financial condition/income.
7. Financial assistance may be denied or delayed for any new requests if the responsible party has not met their payment obligation regarding any amounts due from prior financial assistance.
8. Financial assistance applications that have been sent multiple times to the responsible party will not automatically get an extension of another 30 days in order to complete the forms. The Financial Counselor may consider on a case by case basis, a shorter or longer period of time for the application to be returned.

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 Financial Counselor within 30 days of receiving notification of denial. The Financial Counselor will review all appeals and forward to Patient Financial Services Manager. Once the Manager makes a determination, the CFO will review for final approval. The responsible party will be notified of the appeals outcome. Collection follow up on accounts will be suspended during the appeal process.

COLLECTIONS:
Patient accounts are due in full unless a payment agreement has been established. Patient accounts that are not paid in full (or in the case where payment arrangements have been made, the payments are not made on time) may be turned over to Collections. The Collection Agency is authorized to initiate any and all legal proceedings for collections against the patient or Guarantor as may be deemed appropriate.