

Scope: This policy applies all hospital operations

Purpose: To put in place charity care procedures that comply with RCW 70.170.060(5)

Statement: This policy pertains to charity care procedures at Snoqualmie Valley Hospital and Clinics

Snoqualmie Valley Hospital is committed to ensuring our patients get the hospital care they need regardless of ability to pay for that care. Providing health care to those who cannot afford to pay is part of our mission and state law requires hospitals to provide free and discounted care to eligible patients. You may qualify for free or discounted care based on family size and income, even if you have health insurance.

If you think you may have trouble paying for your health care, please talk with us. When possible, we encourage you to ask for financial help before receiving medical treatment.

What Is Covered? For emergency and other appropriate hospital-based services at Snoqualmie Valley Hospital we provide free care and financial assistance/charity care to eligible patients on a sliding fee scale basis, with discounts ranging from 0_ to 100__%.¹ No patient eligible for financial assistance/charity care will be charged more than amounts generally billed to patients who have insurance .

How to Apply: Any patient may apply to receive financial assistance/charity care by submitting an application and providing supporting documentation. If you have questions, need help, or would like to receive an application form or more information, please contact us:

- When you are checking in or checking out of the hospital;
- By telephone: 425-831-2310
- On our website at: <http://snoqualmiehospital.org/wp-content/uploads/Financial-Aid-Application-Packet.pdf>
- In person: **9801 Frontier Ave SE, Snoqualmie WA 98065, 35020 SE Frontier Street Snoqualmie, WA 98065**
- To obtain documents via mail free of charge: **Business Office 425-831-2310**

If English is Not Your First Language: Translated versions of the application form, are available upon request.

Other Assistance:

Coverage assistance: You may be eligible for other government and community programs. We can help you learn whether these programs (including Medicaid/Apple Health and Veterans Affairs benefits) can help cover your medical bills. We can help you apply for these programs.

Uninsured discounts: We offer a discount for patients who do not have health insurance coverage. Please contact us about our discount program.

Payment plans: Any balance for amounts owed by you is due within 30 days. The balance can be paid in any of the following ways: credit card, payment plan, cash, check, or online bill pay. If you need a payment plan, please call the number on your billing statement.

Emergency Care: Snoqualmie Valley Hospital has a dedicated emergency department and provides care for emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act) without discrimination consistent with available capabilities, without regard to whether or not a patient has the ability to pay or is eligible for financial assistance.

Thank you for trusting us with your care.

1. RCW 70.170.060

- (1) "Department" means the Washington state department of health
- (2) "Hospital" means Snoqualmie Valley Hospital
- (3) "Hospital-Based Clinic" means a department of the Hospital that meets the definition of a provider-based clinic as defined in 42 CFR Sec. 413.65
- (3) "Manual" means the *Washington State Department of Health Accounting and Reporting Manual for Hospitals*
- (4) "Indigent persons" means individuals who reside within King County Public Hospital District No. 4's taxing district who become patients of the hospital and who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 300% of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payor;
- (5) "Financial Assistance" means appropriate hospital-based medical services provided to indigent persons, as defined in this section;

(6) "Bad debts" means uncollectible amounts, excluding contractual adjustments, arising from failure to pay by patients whose care has not been classified as Financial Assistance;

(7) "Appropriate hospital-based medical services" means those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. For purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all;

(8) "Medical staff" means physicians, dentists, nurses, and other professional individuals who have admitting privileges to the hospital, and may also participate as members of the medical staff committees, serve as officers of the medical staff, and serve as directors or chiefs of hospital departments;

(9) "Uninsured" means that the responsibility to pay for services rendered falls directly on the individual without any intervening third-party. "Uninsured" does not apply to co-payments or deductible amounts for which an individual is responsible after a third party has paid their part under the terms of an individual or group policy including Medicare and Medicaid.

(10) "Third-party coverage" and "third-party sponsorship" means an obligation on the part of an insurance company or governmental program which contracts with hospitals and patients to pay for the care of covered patients and services, and may include settlements, judgments, or awards actually received related to the negligent acts of others which have resulted in the medical condition for which the patient has received hospital services;

(11) "Unusually costly or prolonged treatment" means those services or combinations of services which exceed two standard deviations above the average charge, and/or three standard deviations above the average length of stay, as determined by the department's discharge data base;

(12) "Emergency care or emergency services" means services provided for care related to an emergency medical or mental condition;

(13) "Emergency department" and "emergency room" means that portion of the hospital facility organized for the purpose of providing emergency care or emergency services;

(14) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in

(a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) Serious impairment of bodily functions;

(c) Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions the term shall mean:

(d) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(e) That transfer may pose a threat to the health or safety of the woman or the unborn child;

(15) "Responsible party" means that individual who is responsible for the payment of any hospital charges which are not subject to third-party sponsorship;

(16) "Limited medical resources" means the non-availability of services or medical expertise which are required or are expected to be required for the appropriate diagnosis, treatment, or stabilization per federal requirements of an individual's medical or mental situation;

(17) "Publicly available" means posted or prominently displayed within public areas of the hospital, and provided to the individual in writing and explained, at the time that the hospital requests information from the responsible party with regard to the availability of any third-party coverage, in any language spoken by more than ten percent of the population in the hospital's service area, and interpreted for other non-English speaking or limited-English speaking or other patients who can not read or understand the writing and explanation;

(18) "Income" means total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to the individual;

(19) "Family" means a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family;

(20) "Initial determination of sponsorship status" means an indication, pending verification, that the services provided by the hospital may or may not be covered by third party sponsorship, or an indication from the responsible party, pending verification, that he or she may meet the criteria for designation as an indigent person qualifying for Financial Assistance; and

(21) "Final determination of sponsorship status" means the verification of third party coverage or lack of third party coverage, as evidenced by payment received from the third party sponsor or denial of payment by the alleged third party sponsor, and verification of the responsible party's qualification for classification as an indigent person, subsequent to the completion of any appeals to which the responsible party may be entitled and which on their merits have a reasonable chance of achieving third-party sponsorship in full or in part.

Uniform procedures for the identification of indigent persons.

For the purpose of identifying those patients that will be classified as indigent persons the following will apply:

(1) The initiation of collection efforts directed at the responsible party is *precluded* pending an initial determination of sponsorship status, provided that the responsible party is cooperative with the hospital's efforts to reach an initial determination of sponsorship status;

(a) Collection efforts shall include any demand for payment or transmission of account documents or information which is not clearly identified as being intended solely for the purpose of transmitting information to the responsible party;

(b) The initial determination of sponsorship status shall be completed at the time of admission or as soon as possible following the initiation of services to the patient;

(c) If the initial determination of sponsorship status indicates that the responsible party may meet the criteria for classification as an indigent person, as described in WAC 246-453-040, collection efforts directed at the responsible party are precluded pending a final determination of that classification, provided that the responsible party is cooperative with the hospital's reasonable efforts to reach a final determination of sponsorship status;

(d) During the pendency of the initial determination of sponsorship status and/or the final determination of the applicability of indigent person criteria, hospital may pursue reimbursement from any third-party coverage that may be identified to the hospital;

(2) Notice shall be made publicly available that charges for services provided to those persons meeting the criteria established within WAC 246-453-040 may be waived or reduced.

(3) Any responsible party who has been initially determined to meet the criteria identified within WAC 246-453-040 shall be provided with at least fourteen calendar days or such time as the person's medical condition may require, or such time as may reasonably be necessary to secure and to present documentation as described within WAC 246-453-030 prior to receiving a final determination of sponsorship status.

(4) Hospital will make every reasonable effort to determine the existence or nonexistence of third-party sponsorship that might cover in full or in part the charges for services provided to each patient.

(5) Hospital will require potential indigent persons to complete its application process and attest to the accuracy of the information provided to the hospital for purposes of determining the person's qualification for Financial Assistance sponsorship. Hospital does not impose application procedures for Financial Assistance sponsorship which place an unreasonable burden upon the responsible party, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the responsible party's capability of complying with the application procedures. The failure of a responsible party to reasonably complete appropriate application procedures shall be sufficient grounds for the hospital to initiate collection efforts directed at the patient.

(6) Hospital will not require a deposit from responsible parties meeting the criteria identified within WAC 246-453-040 (1) or (2), as indicated through an initial determination of sponsorship status.

(7) Hospital will notify persons applying for Financial Assistance sponsorship of their final determination of sponsorship status within fourteen calendar days of receiving information in accordance with WAC 246-453-030; such notification must include a determination of the amount for which the responsible party will be held financially accountable.

(8) In the event that the hospital denies the responsible party's application for Financial Assistance sponsorship, the hospital must notify the responsible party of the denial and the basis for that denial.

(9) All responsible parties denied Financial Assistance sponsorship under WAC 246-453-040 (1) or (2) shall be provided with, and notified of, an appeals procedure that enables them to correct any deficiencies in documentation or request review of the denial and results in review of the determination by the hospital's chief financial officer or equivalent.

(a) Responsible parties shall be notified that they have thirty calendar days within which to request an appeal of the final determination of sponsorship status. Within the first fourteen days of this period, the hospital may not refer the account at issue to an external collection agency. After the fourteen day period, if no appeal has been filed, hospital may initiate collection activities.

(b) If the hospital has initiated collection activities and discovers an appeal has been filed, they shall cease collection efforts until the appeal is finalized.

(c) In the event that the hospital's final decision upon appeal affirms the previous denial of Financial Assistance designation under the criteria described in WAC 246-453-040 (1) or (2), the responsible party and the department of health shall be notified in writing of the decision and the basis for the decision, and the department of health shall be provided with copies of documentation upon which the decision was based.

(10) Hospital will make every reasonable effort to reach initial and final determinations of Financial Assistance designation in a timely manner; however, hospital may make those designations at any time upon learning of facts or receiving documentation, as described in WAC 246-453-030, indicating that the responsible party's income is equal to or below three hundred percent of the federal poverty standard as adjusted for family size. The timing of reaching a final determination of Financial Assistance status shall have no bearing on the identification of Financial Assistance deductions from revenue as distinct from bad debts.

(11) In the event that a responsible party pays a portion or all of the charges related to appropriate hospital-based medical care services, and is subsequently found to have met the Financial Assistance criteria at the time that services were provided, any payments in excess of the amount determined to be appropriate in accordance with WAC 246-453-040 shall be refunded to the patient within thirty days of achieving the Financial Assistance designation.

Data requirements for the identification of indigent persons.

(1) For the purpose of reaching an *initial* determination of sponsorship status, hospital shall rely upon information provided orally by the responsible party. The hospital may require the responsible party to sign a statement attesting to the accuracy of the information provided to the hospital for purposes of the initial determination of sponsorship status.

(2) Any one of the following documents shall be considered sufficient evidence upon which to base the final determination of Financial Assistance sponsorship status, when the income information is annualized as may be appropriate:

(a) A "W-2" withholding statement;

(b) Pay stubs;

(c) An income tax return from the most recently filed calendar year;

(d) Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance;

(e) Forms approving or denying unemployment compensation; or

(f) Written statements from employers or welfare agencies.

(3) In the event that the responsible party's identification as an indigent person is obvious to hospital personnel, and the hospital personnel are able to establish the position of the income level within the broad criteria described in WAC 246-453-040 or within income ranges included in the hospital's sliding fee schedule, the hospital is not obligated to establish the exact income level or to request the aforementioned documentation from the responsible party, unless the responsible party requests further review.

(4) In the event that the responsible party is not able to provide any of the documentation described above, the *hospital shall rely upon written and signed statements from the responsible party* for making a final determination of eligibility for classification as an indigent person.

(5) Information requests, from the hospital to the responsible party, for the verification of income and family size shall be limited to that which is reasonably necessary and readily available to substantiate the responsible party's qualification for charity sponsorship, and may not be used to discourage applications for such sponsorship. Only those facts relevant to eligibility may be verified, and duplicate forms of verification shall not be demanded.

Sliding fee schedule.

Snoqualmie Valley Hospital shall adopt and maintain a sliding fee schedule for determination of discounts from billed charges for responsible parties meeting the criteria in WAC 246-453-040(2). These sliding fee schedules will be made available upon request.

(1) In developing these sliding fee schedules, hospital considers the following guidelines:

(a) The sliding fee schedule shall consider the level of charges that are not covered by any public or private sponsorship in relation to or as a percentage of the responsible party's family income;

(b) The sliding fee schedule shall determine the maximum amount of charges for which the responsible party will be expected to provide payment, with flexibility for hospital management to hold the responsible party accountable for a lesser amount after taking into account the specific financial situation of the responsible party;

(c) The sliding fee schedule shall take into account the potential necessity for allowing the responsible party to satisfy the maximum amount of charges for which the responsible party will be expected to provide payment over a reasonable period of time, without interest or late fees; and

(d) Hospital may consider the following conditions for purposes of adjusting the amounts to be paid or considered as Financial Assistance resulting from the application of the sliding fee schedule. All adjustments must be approved by the Chief Financial Officer:

(i) Extraordinary nondiscretionary expenses relative to the amount of the responsible party's medical care expenses;

(ii) The existence and availability of family assets, which may only be considered with regard to the applicability of the sliding fee schedule;

(iii) The responsible party's future income earning capacity, especially where his or her ability to work in the future may be limited as a result of illness; and

(iv) The responsible party's ability to make payments over an extended period.

(2) The following sliding fee schedule guidelines shall apply for purposes of determining eligibility for Financial Assistance:

(a) A person whose annual family income is between one hundred one and three hundred percent of the federal poverty standard, adjusted for family size, shall have his/her hospital charges that are not covered by public or private sponsorship reduced according to the schedule below. The resulting responsibility may be adjusted by appropriate hospital personnel after taking into consideration the individual financial circumstances of the responsible party.

The responsible party's financial obligation which remains after the application of this sliding fee schedule may be payable in monthly installments over a reasonable period of time, without interest or late fees, as negotiated between the hospital and the responsible party. The schedule is as follows:

INCOME AS A PERCENTAGE OF FEDERAL POVERTY LEVEL	PERCENTAGE DISCOUNT
150% or Lower	One Hundred Percent (100%)
One-hundred-one to one-hundred-fifty (101% to 150%)	Eighty percent (80%)
One hundred fifty-one to one hundred seventy-five (151% to 175%)	Seventy percent (70%)
One-hundred-seventy-six to two-hundred (176% to 200%)	Sixty percent (60%)
Two-hundred-one to two-hundred-fifty (201% to 250%)	Fifty percent (50%)
Two-hundred-fifty-one to three-hundred (251% to 500%)	Twenty-five percent (30%)

(3) The provisions of this section and RCW 70.170.060(5) shall not apply to the professional services of the hospital's medical staff, provided that the charges for such services are either submitted by the individual medical staff or are separately identified within the hospital's billing system.

Uninsured Patients.

(1) Discounts calculated with the sliding scale contained in this policy ensure that any uninsured person who applies for charity care and whose income is between 100% and 200% of the Federal Poverty Level adjusted for family size is not charged more than the estimated cost of her/his hospital-based care based on the hospitals current cost to charge ratio.

(2) Discounts calculated with the sliding scale contained in this policy ensure that any uninsured person who applies for charity care and whose income is between 200% and 300% of the Federal Poverty Level adjusted for family size is not charged more than 130% of the cost of her/his hospital-based care based on the hospitals current cost to charge ratio.

Denial of access to emergency care based upon ability to pay and transfer of patients with emergency medical conditions or active labor.

(1) The hospital or its medical staff shall not adopt or maintain admission practices or policies which result in:

(a) A significant reduction in the proportion of patients who have no third-party coverage and who are unable to pay for hospital services;

(b) A significant reduction in the proportion of individuals admitted for inpatient hospital services for which payment is, or is likely to be, less than the anticipated charges for or costs of such services; or

(c) The refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital.

(2) The hospital shall not adopt or maintain practices or policies which would deny access to emergency care based on ability to pay. Snoqualmie Valley Hospital will not transfer a patient who has an emergency medical condition or who is in active labor unless the transfer is performed at the request of the patient or is due to the limited medical resources of the hospital.

(3) Except as required by federal law and subsection (2) of this section, nothing in this section shall be interpreted to indicate that the hospital or its medical staff are required to provide appropriate hospital-based medical services, including experimental services, to any individual.

Reporting policies for Financial Assistance and bad debts.

(1) The hospital shall submit to the department its Financial Assistance policies, procedures, and sliding fee schedules consistent with the requirements included in WAC [246-453-020](#), [246-453-030](#), [246-453-040](#), and [246-453-050](#). Any subsequent modifications to those policies, procedures, and sliding fee schedules must be submitted to the department no later than thirty days prior to their adoption by the hospital.

(2) The hospital shall develop, and submit to the department, bad debt policies and procedures, including reasonable and uniform standards for collection of the unpaid portions of hospital charges that are the patient's responsibility.

These standards are to be part of each hospital's system of accounts receivable management manuals, which support hospital collection policies. Manuals should cover procedures for preadmission, admission, discharge, outpatient registration and discharge, billing, and credit and collections. All subsequent modifications to these bad debt policies must be submitted to the department no later than thirty days prior to their adoption by the hospital.

References

Reference Type	Title	Notes
Documents referenced by this document		
Referenced Documents	246-453-020	
Referenced Documents	246-453-030	
Referenced Documents	246-453-040	
Referenced Documents	246-453-050	
Referenced Documents	70.170.060	
Referenced Documents	246-453-020	
Referenced Documents	246-453-030	
Referenced Documents	246-453-040	
Referenced Documents	246-453-050	

Referenced Documents

70.170.060

Signed by

Steve Daniel

Steve Daniel, Chief Financial Officer

(10/11/2018 04:44PM PST)

Kim Witkop

Kim Witkop, Chief Medical Officer

(10/11/2018 05:25PM PST)

Tom Parker

Tom Parker, CEO

(10/11/2018 05:51PM PST)

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