



Financial Assistance Policy and Procedure

Purpose

In accordance with our Mission, Vision, and Values Statement, Astria Health believes it is imperative to provide our patients with not only the best medical care and accessibility that we can provide, but to also extend our commitment to our patients throughout the entire billing process in compliance with 501(r)(4A) and Washington Administrative Code (WAC), Chapter 246-453. It is the goal of Astria Health to provide quality care regardless of a patient's ability to pay for services. The application process is not intended to impose an undue burden on the responsible party considering any physical, mental, intellectual sensory deficiencies or language barriers which may hinder the responsible party's capability of complying with the application procedures. Applicants shall be given 14 days from the application date to provide documentation, during which time no collection efforts will occur.

Audience

Individuals receiving care at Astria Health hospitals and clinics and Astria Health personnel or representatives.

Key Concepts and Terms

For the purpose of this policy, the terms below are defined as follows:

Charity Care: The definition of Charity Care, as defined within RCW 70.170.020 (4) is "Charity care" means medically necessary hospital health care rendered to indigent persons when third-party coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer, as determined by the department. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: The Census Bureau and WAC 246-453-010 (18) definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption.

Family Income: as defined within WAC 246-453-010 (17) is "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;

o If a person lives with a family, includes income of all family members. (Non-relatives, such as housemates, do not count.)

Uninsured: The patient has no level of insurance or third-party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.



Gross Charges: The total charges at the organization's full established rates for the provision of patient care services before deduction from revenue are applied.

Emergency Medical Conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically Necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

Poverty Guidelines: The poverty guidelines are a simplified version of the Federal Government's statistical poverty thresholds used by the Bureau of Census to prepare its statistical estimates of the number of persons and families in poverty. The poverty guidelines are used primarily for statistical purposes. However, the Department of Health and Human Services uses the thresholds for administrative assistance or services under a particular federal program. Other programs, such as our Financial Assistance Program, use the guidelines for the purpose of giving priority to lower income persons or families in the provision of assistance or services. Our poverty guidelines are based on last (calendar) year's increase in prices as measured by the Consumer Price Index. The poverty guidelines are published in the Federal Register and are revised yearly.

Amounts Generally Billed (AGB): No person eligible for financial assistance under the FAP will be charged more for medically necessary care than amounts generally billed (AGB) to individuals who have insurance covering such care. Astria Health determines AGB based on all claims paid in full to Astria Health by Medicaid and/or private health insurers over a 12-month period, divided by the associated gross charges for those claims.

Policy

In accordance with State and Federal Law, our Financial Services Department offers financial assistance to qualified patients who are exempt from insurance in accordance with the ACA (Affordable Care Act) or are underinsured and do not have adequate resources to pay for medically necessary services that have been provided. Emergent and Medically Necessary services are eligible for coverage under the Financial Assistance Program (FAP). Financial assistance applications are processed in accordance with the policy. No patient/resident that meets these requirements shall be denied uncompensated health care based upon race, creed, color, sex, national origin, sexual orientation, disability, age, or source of income.

Our program is a payer of last resort, the Affordable Care Act (ACA) states that everyone must have insurance, but Astria Health does consider hardship and debt ratio for those who are uninsured and do not qualify for subsidized insurance plans (i.e. Medicaid). If the financial counselor believes that another program could be utilized and was denied, a denial will be requested before consideration can be given. If the denial cannot be obtained, our financial counselors will then work with the patient to arrange payment terms, based on the unique circumstances and in accordance with Astria Health's payment policy.

Astria Health's financial assistance program is administered in conjunction with the Federal Poverty Guidelines that are used nationwide and that pertain to medical services provided at Astria Health only. These guidelines incorporate rationale for age, number and ages of dependents and provide definitions of family and gross income. The United States



Department of Health and Human Services sets the Federal Poverty Income Guidelines and applies annual revisions to account for increases in the Consumer Price Index.

Astria Health utilizes the federal poverty income levels for eligibility purposes. The guarantor's household gross income is compared to this poverty level. If this total is at or below the 300% level, 100% of the patient responsibility balance on approved accounts will be forgiven.

Astria does not consider the existence, availability, and value or assets in order to reduce the charity care discount.

Procedure

Eligibility Requirements

1. Astria Health's Financial Assistance Program shall be consistently and equitably administered in accordance with established eligibility requirements. Astria Health employs staff whose role it is to screen for uninsured patients and visits and proactively reach out to patients to assist them in applying for sources of Medical coverage such as Medicaid, ACA Marketplace plans, and direct them to Financial Assistance applications as needed or requested these staff are certified Navigators for the State of Washington.
2. All patients with a self-pay balance may be eligible for financial assistance which can include free or discounted care. However, financial assistance generally excludes care found not to be medically necessary, or disallowed by government or third-party payers including procedures considered elective, experimental or cosmetic in nature.
3. The full application process must be completed, preferably by the patient/responsible party. Falsification of the application information, failure to fully disclose all assets and/or income, or refusal to cooperate will result in denial of the financial assistance application.
4. All third-party resources and non-hospital financial aid programs, including public assistance available through the state Medicaid program must be exhausted before financial assistance can be considered. If an individual has applied for and has not yet received a determination, the eligibility for financial assistance will be postponed until the Medicaid Eligibility determination has been made.
5. Prima Facie Write Offs: In the event that the responsible party's identification as an indigent person is obvious to Astria Health's personnel and they can establish that the applicant's income is clearly within the range of eligibility, Astria Health will grant Charity Care based solely on this initial determination. In these cases, Astria Health is not required to complete a full verification or documentation. (in accordance with WAC 246-453-030(3)).

Method for applying for financial assistance:

The Financial Assistance Application (Attachment C) can be completed before or after services are provided.



The forms may be completed by the applicant at home or onsite with the assistance of Patient Financial Services personnel. All required supporting documentation must be included with the application.

The application can be obtained as described in the section below:

By Telephone: 509-837-1554

At our address: Astria Health, 1016 Tacoma Avenue, Sunnyside, WA 98944

On our website: <https://www.astria.health>

A patient will not be deferred or denied medically necessary care based on the non-payment of previously provided care, if financial assistance has not yet been determined.

Extraordinary Collection Actions (ECA):

Astria Health will not take any ECA actions without making a reasonable effort to determine at patient's financial assistance eligibility in accordance with limitations outlined in the policy.

Measures to widely publicize this policy within the community served by the facility:

1. Financial Counselors will make paper copies of the financial assistance policy, application, attachment B) and plain language summary (Attachment A).
 - The paper copies are available upon request and without charge.
 - Documents are readily available during normal business hours either directly from the Financial Counselor or by mail.
 - Each document is available in English and in the primary language of any populations with limited proficiency in English that constitutes more than either (a) 1,000 individuals or (b) 5% of the residents of the community serviced by the facility, whichever is less.
2. As part of the intake or discharge process, patients are offered a Patient Information Packet that outlines payment plan options and Financial Assistance Policy information including the Plain Language Summary (Attachment A).
3. Notify and inform members of the community served by the hospital facility about the Financial Assistance Policy with the information available on each billing statement.
4. Astria Health's financial assistance contact information is posted on the home page of the facility website at <https://www.astria.health>
5. The financial assistance documents can be accessed, downloaded, viewed and printed from the website.

Administration/Guidelines of Financial Assistance Program:



1. Astria Health Financial Assistance Program will be administered according to the following guidelines:
 - a. Astria will make an initial determination of potential eligibility based on the verbal request for charity care. Pending final eligibility determination, the hospital will not initiate collection efforts or requests for deposits, provided that the responsible party cooperates with hospital efforts to obtain payment from other sources, including Medicaid.
 - b. Astria will furnish an application and instructions to the responsible party when charity care is requested, or when financial screening indicates potential need. The responsible party will return a completed application as soon as possible, but not to exceed 14 days from date of request.
 - c. The application information, along with all the required documentation will be reviewed by the Patient Financial Counselor.
 - d. Patient Financial Counselor will complete the Worksheet for Annual Income, Worksheet for Income and Asset Calculation, and Worksheet for Discount Calculation.
 - e. After reviewing the application, the CFO or designee will determine if the patient/responsible party qualified for financial assistance based on the supporting documentation and the recommendation of the Patient Financial Counselor who verified the information contained in the application.
 - f. Patient Accounts Data Entry personnel will write off approved amounts from the patient's account(s) per established procedures.
 - g. The patient/responsible party will be notified in writing within thirty (30) days from applying (when all documentation has been received) if they were approved for financial assistance.
 - h. The application will be kept on file for seven (7) years.
 - i. Providing the patient/responsible party's finances change significantly between tax seasons, current income for the household as defined in Attachment C will determine eligibility in lieu of the federal income tax requirements. An approved application will be a one-time grant.
 - j. If an applicant is habitually non-compliant with the program guidelines and assistance efforts made by the financial counselors and staff, the applicant may be required to submit a fully completed application with all required documents prior to a non-emergent service(s).
Astria may initiate collection efforts for failure to complete application, patient balances will be eligible for collection and credit reporting after 30 days from the date of service.

Appeal Process:

1. The patient/responsible party has the right to appeal the financial assistance decision.
2. The appeal must be received within thirty (30) days of the determination.



3. The appeal must include documented proof justifying why the patient/responsible party is unable to pay.
4. The appeal is forwarded to the Business Office Manager and is reviewed with the CFO.
5. The patient/responsible party will be notified within sixty (60) days from submission of the appeal if they are approved.
6. Per WAC 246-453-020 (9)(c): "In the event that the hospital's final decision upon appeal affirms the previous denial of charity care 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." Astria Health will notify the responsible party in writing of the decision and the basis for the decision as well as provide the Department of Health with copies of all documentation pertaining to the decision.

Implementation/Education Plan:

Policy will be reviewed and implemented by Provider Financial Services Staff.

Related Documents:

- Attachment A: Plain Language Document
- Attachment B: FA Acuity Indicator
- Attachment C: Assistance Application

References:

- 501(r)(4A) and Washington Administrative Code (WAC), Chapter 246-453
- WAC 246-453-030(3)
- WAC 246-453-020(10)

Astria Health Hospitals and Clinics

- Astria Sunnyside Community Hospital
- Astria Toppenish Hospital (SHC Medical Center- Toppenish)
- SHC Medical Center Yakima
- Ahtanum Ridge Family Medicine
- Vintage Valley Family Medicine
- Central Washington Occupational Medicine – Toppenish
- Central Washington Surgical Associates – Toppenish
- Cardiac & Thoracic Institute of Central Washington
- Valley Medi-Center
- Westside Medi-Center



- Selah Clinic
- Summitview Family Medicine
- Terrace Heights Family Physicians
- Central Washington Occupational Medicine – Yakima
- Central Washington Orthopedic Surgeons
- Central Washington Surgical Associates – Yakima
- Central Valley Vascular Center
- Central Washington Rehabilitation Clinic
- Central Washington Anesthesia Services
- Central Valley Gastroenterology - Yakima
- Sunnyside Dental
- Yakima Home Care
- Yakima Regional Home Health
- Spavinaw Dental

Department: Provider Financial Services	Document Owner: Danielle Lyzanchuk	Effective Date: 3/1/2022
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Plain Language Summary of Financial Assistance/Charity Care Policy

Astria Health 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 medically necessary hospital health care at Astria Health we provide free care and financial assistance/charity care to eligible patients, with discounts up to 100%. 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: 509-837-1554
- On our website at: <https://www.astria.health/patients-visitors/financial-information/>
- In person: Astria Health, 1016 Tacoma Avenue, Sunnyside, WA 98944
- To obtain documents via mail free of charge: Contact Astria Health Business Office at 509-837-1554

If English is Not Your First Language: Translated versions of the application form, financial assistance policy, and this summary, 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: Astria Health 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.



Financial Assistance Acuity Indicators

PURPOSE

The 501r tax regulation requires that financial assistance policies define what services are eligible for coverage under financial assistance. Astria Health will consider services that are defined as urgent and semi-urgent, by the treating clinical provider, in the financial assistance process.

Elective services are not considered for financial assistance. Occasionally the level of urgency may be increased based on a special consideration/hardship that is well documented by the provider and/or applicable financial assistance committee staff.

A non-emergent service treated in an emergent setting will not be considered emergent for the purpose of financial assistance. The level of urgency is based on the clinical opinion of the treating clinician and not the location of the service.

URGENT / EMERGENT / NON-ELECTIVE

Urgent/emergent/non-elective services are those deemed necessary, in the opinion of the treating clinician, to save life and/or limb. A condition causing severe pain, dysfunction, or disability and cannot be delayed more than 24 hours.

SEMI-URGENT / SEMI-EMERGENT / SEMI-ELECTIVE

Semi-urgent/semi-emergent/semi-elective care are those services deemed necessary, in the opinion of the treating clinician, to preserve the patient's life/limb, but do not need to be performed immediately. A condition causing moderate pain, dysfunction, or disability and is likely to deteriorate quickly or become an emergency.

ELECTIVE

Care at some time in the future for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.

SPECIAL CONSIDERATIONS / HARDSHIP

The level of urgency for any given service may be increased based on special considerations/hardship. Patients, family of patients, clinicians, and Patient Financial Services staff can request that medical services be reviewed on a case by case basis. Special considerations may include but are not limited to those listed below:

- Diagnosis (i.e. cancer)
- Potential to deteriorate to an emergency situation
- Patient demographics (travel hardship)
- Availability of external resource
- Patient co-morbidities
- Mental/emotional health
- Level of pain/dysfunction/disability
- Continuation of care for traumatic injury/illness
- Confirmed Active Out of State Medicaid Coverage (non-elective services only)



Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at Astria Health.

Washington State requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. Astria Health utilizes the federal poverty income levels to determine eligibility for financial assistance. The guarantor's household gross income is compared to this poverty level. If this total is at or below the 300% level, 100% of the patient responsibility balance on approved accounts will be forgiven.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by Astria Health depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Visit us at Astria Health, Astria Health, 1016 Tacoma Avenue, Sunnyside, WA 98944 or call our Business Office at 509-837-1554. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- Provide us information about your family**
Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Provide us information about your family's gross monthly income (income before taxes and deductions)**
- Provide documentation for family income**
- Attach additional information if needed**
- Sign and date the form**

Note: You do not have to provide a Social Security number to apply for financial assistance. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail or fax completed application with all documentation to: Astria Health, 1016 Tacoma Avenue, Sunnyside, WA 98944. Be sure to keep a copy for yourself.

To submit your completed application in person: Astria Health, 1016 Tacoma Avenue, Sunnyside, WA 98944, Our hospital is open 24 hrs a day. Our Business office phone number is 509-837-1554.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly!
You may receive bills until we receive your information.



Charity Care/Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION
Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, list preferred language:</i>
Has the patient applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>May be required to apply before being considered for financial assistance</i>
Does the patient receive state public services such as TANF, Basic Food, or WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient's medical care need related to a car accident or work injury? <input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE NOTE
<ul style="list-style-type: none"> We cannot guarantee that you will qualify for financial assistance, even if you apply. Once you send in your application, we may check all the information and may ask for additional information or proof of income. Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION			
Patient first name	Patient middle name	Patient last name	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (may specify _____)	Birth Date	Patient Social Security Number (optional*) <i>*optional, but needed for more generous assistance above state law requirements</i>	
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) <i>*optional, but needed for more generous assistance above state law requirements</i>
Mailing Address _____ _____ City State Zip Code			Main contact number(s) () _____ () _____ Email Address: _____
Employment status of person responsible for paying bill <input type="checkbox"/> Employed (date of hire: _____) <input type="checkbox"/> Unemployed (how long unemployed: _____) <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other (_____)			

FAMILY INFORMATION					
List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.					
FAMILY SIZE _____			<i>Attach additional page if needed</i>		
Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain* _____)



Charity Care/Financial Assistance Application Form – confidential

INCOME INFORMATION

REMEMBER: *You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

Examples of proof of income include:

- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Astria Health may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

Signature of Person Applying

Date