Providence SWEDISH

Rehabilitation Hospital

**SUBJECT:** **CHARITY CARE**
**Policy:** **BO 165**
**Effective Date:** **8/14/2024**
**Revision Date:**

***Business Office Policies and Procedures***

# Providence Swedish Rehabilitation Hospital
# Charity Care/Financial Assistance

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**Scope:**
This policy applies to Northwest Washington Rehabilitation Hospital, LLC DBA: Providence Swedish Rehabilitation Hospital per the Partnership Agreement between Providence Washington ("Providence") and Providence Swedish Rehabilitation Hospital.

This policy shall be interpreted in a manner consistent with Section 501(r) of the Internal Revenue Code of 1986, as amended and with Chapter 70.170.060 of the Revised Washington Code, as amended. In the event of a conflict between the provisions of such laws and this policy, such laws shall control.

**Purpose:**
To reflect the commitment of Providence Swedish Rehabilitation Hospital to ensure a fair, non-discriminatory, effective, and uniform method for the provision of financial assistance (charity care) to eligible individuals who are unable to pay in full or part for medically necessary hospital health care and other hospital services provided by Providence Swedish Rehabilitation Hospital, in accordance with the Partnership Agreement between Providence and Providence Swedish Rehabilitation Hospital.

It is the intent of this policy to comply with all federal, state, and local laws.

**Definitions:**
1. Federal Poverty Level (FPL): FPL means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services.
2. Amounts Generally Billed (AGB): The amounts generally billed for medically necessary care to patients who have health insurance is referred to in this policy as AGB. Providence Swedish Rehabilitation Hospital determines the applicable AGB percentage by multiplying the hospital's gross charges for medically necessary care by a fixed percentage which is based on claims allowed under Medicare and commercial payors.

**Policy:**
In accordance with the Partnership Agreement between Providence and Providence Swedish Rehabilitation Hospital, Providence Swedish Rehabilitation Hospital is required to adopt the Charity Care Policy of Providence.

Providence Swedish Rehabilitation Hospital will provide free or discounted hospital services to qualified low income, uninsured and underinsured patients who are at or below 400% of the FPL, when other

hospital care and no alternative source of coverage has been identified. Patients must meet the eligibility requirements described in this policy to qualify.

Providence Swedish Rehabilitation Hospital will not discriminate on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law when making financial assistance determinations.

Financial Assistance Eligibility Requirements: Financial assistance is available to both uninsured and insured patients and guarantors where such assistance is consistent with this policy and federal and state laws governing permissible benefits to patients. Providence Swedish Rehabilitation Hospital will make a reasonable effort to determine the existence or nonexistence of third-party coverage which may be available, in whole or part, or sponsorship status for charity care, for the care provided by Providence Swedish Rehabilitation Hospital, prior to directing any collection efforts at the patient.

When a patient or their guarantor may be eligible for coverage through medical assistance programs under chapter 74.09 RCW or the Washington health benefit exchange or is determined to be qualified for retroactive health care coverage through the medical assistance programs under chapter 74.09 RCW, Providence Swedish Rehabilitation Hospital will provide assistance to the patient or guarantor with applying for such coverage. Denial of charity care/financial assistance due to a patient's failure to make reasonable efforts to cooperate with the hospital in applying for coverage is limited to medical assistance programs under chapter 74.09 RCW only. Providence Swedish Rehabilitation Hospital will not place unreasonable burdens on the patient or guarantor during the application process for financial assistance and retroactive coverage, taking into account any physical, mental, intellectual, or sensory deficiencies, or language barriers which may hinder the responsible party's capability of complying with application procedures. Patients who are obviously or categorically ineligible or have been deemed ineligible in the prior 12 months for a state or federal program will not be required to apply for such programs in order to receive financial assistance.

Uninsured patients may receive an uninsured discount prior to financial assistance eligibility verification. Eligible financial assistance balances include but are not limited to the following: uninsured or self-pay patients, charges for insured patients with coverage from an entity without a contractual relationship, coinsurance, deductible, and copayment amounts related to insured patients. Deductible and coinsurance amounts claimed as a Medicare bad debt will be excluded from the reporting of charity care.

Patients seeking financial assistance must complete the standard Financial Assistance Application and eligibility will be based upon financial need as of the date of service or as of the date of application, whichever indicates the lower amount of income and greatest financial need. Patients may re-apply for assistance if their financial circumstances change even if a previous application was denied or approved in part. Providence Swedish Rehabilitation Hospital will retain information used to determine eligibility in

accordance with its recordkeeping practices.

Applying for Financial Assistance: Patients or guarantors may request and submit a Financial Assistance Application, which is free of charge and available by advising staff at or prior to the time of discharge that assistance is requested and submitted with completed documentation. A person applying for financial assistance will be given a preliminary screening, which will include a review of whether the patient has exhausted or is not eligible for any third-party payment sources and if they may meet the criteria for charity care.

A patient or guarantor who may be eligible to apply for financial assistance may provide sufficient documentation to Providence Swedish Rehabilitation Hospital to support eligibility determination at any time upon learning that their income falls below the minimum Federal Poverty Level (FPL) per the relevant Federal and State regulations. Providence Swedish Rehabilitation Hospital will suspend any collection activities pending an initial determination of eligibility for financial assistance, provided that the patient or their guarantor is cooperative with Providence Swedish Rehabilitation Hospital's reasonable efforts to reach an initial determination. Providence Swedish Rehabilitation Hospital acknowledges that a determination of eligibility of financial assistance or discount can be made at any time upon learning that a party's income is below 400% of the federal poverty standard, adjusted for family size. In addition, Providence may choose to grant financial assistance solely based on an initial determination of a patient's status as an indigent person. In these cases, documentation may not be required.

Individual Financial Situation: Income, certain assets, and expenses of the patient will be used in assessing the patient's individual financial situation. Providence Swedish Rehabilitation Hospital will consider and collect information related to assets as required by the Centers for Medicare and Medicaid Services (CMS) for Medicare cost reporting. Assets considered when making a determination of eligibility for financial assistance shall not include: (A) for a single individual, the first $100,000 of a patient's monetary assets, and 50% of a patient's monetary assets over the first $100,000; (B) for a family of two or more, the first $100,000 of the family's monetary assets, and 50% of the family's monetary assets over the first $100,000; (C) any equity in a primary residence; (D) retirement or deferred compensation plans qualified under the Internal Revenue Code or nonqualified deferred compensation plans; (E) one motor vehicle and a second motor vehicle if it is necessary for employment or medical purposes; (F) any prepaid burial contract or burial plot; and (G) any life insurance policy with a face value of $10,000 or less. The value of any asset that has a penalty for early withdrawal shall be the value of the asset after the penalty has been paid. Information requests from Providence Swedish Rehabilitation Hospital to the responsible party to verify assets will be limited to that which is reasonably necessary and readily available to determine the existence, availability, and value of a person's assets and will not be used to discourage application for free or discounted care. Duplicate forms of verification will not be requested. Only one current account statement will be required to verify monetary assets. If no documentation is available, Providence Swedish Rehabilitation Hospital will rely on a written and signed statement from the responsible party. Any asset information obtained by the hospital in evaluating a patient for charity care will not be used for collection activities and assets will not be considered for households under 300% of the federal poverty level.

Income Qualifications: Income criteria, based on FPL, shall be used to determine eligibility for free or discounted care.

| If... | Then ... |
|---|---|
| Annual family income, adjusted for family size, is at or below 300% of thecurrent FPL guidelines, | The patient is determined to be financially indigent and qualifies forfinancial assistance 100% write-off on patient responsibility amounts. |
| Annual family income, adjusted forfamily size, is between 301% and 400% of the current FPL guidelines, | The patient is eligible for a discount of 75% from original charges onpatient responsibility amounts. |
| If annual family income, adjusted for family size, is at or below 400% the FPL AND the patient has incurred totalmedical expenses at Providence hospitals in the prior 12 months in excess of 20% of their annual family income, adjusted for family size, forservices subject to this policy, | The patient is eligible for 100% charity benefit on patient responsibility amounts. |

Determinations and Approvals: Patients will receive notification of FAP eligibility determination within 14 days of submission of the completed Financial Assistance Application and necessary documentation. Any determination of ineligibility will include an explanation of the basis for denial. Once an application is received, collections efforts will be pended until a written determination of eligibility is sent to the patient. The hospital will not make a determination of eligibility for assistance based upon information which the hospital reasonably believes is incorrect or unreliable.

Dispute Resolution: The patient may appeal a determination of ineligibility for financial assistance by providing relevant additional documentation to the hospital within 30 days of receipt of the notice of denial. The patient may need to provide relevant additional documentation in support of their appeal. Providence Swedish Rehabilitation Hospital will suspend any collection activities pending review of the appeal. All appeals will be reviewed and if the review affirms the denial, written notification will be sent to the guarantor and State Department of Health, where required, and in accordance with the law. The final appeal process will conclude within 10 days of receipt of the denial by the hospital. An appeal may be sent to Providence Swedish Rehabilitation Hospital, Attn: Controller; 12911 Beverly Park Road, Lynnwood, Washington 98087.

Limitation on Charges for all Patients Eligible for Financial Assistance: No patient who qualifies for any of

the above-noted categories of assistance will be personally responsible for more than the Amounts Generally Billed (AGB) percentage of gross charges, as defined below.

Reasonable Payment Plan: Once a patient is approved for partial financial assistance, but still has a balance due, Providence Swedish Rehabilitation Hospital will negotiate a payment plan arrangement. The reasonable payment plan shall consist of monthly payments (without interest or late fees) that are not more than 10 percent of a patient's or family's monthly income, excluding deductions for Essential Living Expenses that the patient listed on their Financial Assistance Application.

Billing and Collections: Any unpaid balances owed by patients or guarantors after application of available discounts, if any, may be referred to collections.

Patient Refunds: In the event that a patient or guarantor has made a payment for services and subsequently is determined to be eligible for free or discounted care, any payments made related to those services during the FAP-eligible time period which exceed the payment obligation will be refunded, in accordance with state regulations.

**References:**
Internal Revenue Code Section 501(r); 26 C.F.R. 1.501(r)(1) – 1.501(r)(7)
Revised Code of Washington (RCW) Chapter 70.170.060

**Attachments:**
Charity Care/Financial Assistance Application Instructions
Charity Care/Financial Assistance Application

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# Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at Providence Swedish Rehabilitation Hospital.

**Federal and state law requires all hospitals to provide financial assistance** to people and families who meet certain income requirements. You may qualify for free care or discounted care based on your family size and income, even if you have health insurance.

**What does financial assistance cover?** The medical financial assistance covers medically necessary care provided Providence Swedish Rehabilitation Hospital depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

**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) to include pay stubs, W-2 forms, tax returns, social security awards letters, and statements for income drawn from assets, and declare and provide documentation for assets.
  (see financial assistance application Income Section for more examples)
- Attach additional information if needed
- Sign and date the financial assistance 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, your Social Security number may be used to identify you or used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."
- Mail completed application with all documentation to: Providence Swedish Rehabilitation Hospital, Attn: Controller; 12911 Beverly Park Road, Lynnwood, Washington 98087.
- To submit your completed application in person: Take to 12911 Beverly Park Road, Lynnwood, Washington 98087.
- We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 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.
- Except as may be prohibited by state law, Providence Swedish Rehabilitation Hospital will collect and consider information related to assets as required by the Centers for Medicare and Medicaid Services (CMS) for Medicare cost reporting.

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## Charity Care/Financial Assistance Application

Please Note

- 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 days after we receive your completed application and documentation, we will notify you of our determination.

*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? □ **Yes** □ **No** *If Yes, list preferred language:* |
| Has the patient applied for Medicaid? □ **Yes** □ **No** Is the patient Blind? □ **Yes** □ **No** Is the patient Disabled? □ **Yes** □ **No** |
| Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** □ **No** |
| Is the patient currently homeless? □ **Yes** □ **No** |
| Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No** |

| PATIENT AND APPLICANT INFORMATION | | | |
|---|---|---|---|
| Patient first name | Patient middle name | | Patient last name |
| □ Male □ Female<br>□ Other (may specify _____) | Birth Date | | Patient Social Security Number (optional) |
| Person Responsible for Paying Bill | Relationship to Patient | Birth Date | Social Security Number (optional) |
| Mailing Address<br>_____<br>_____<br>City State Zip Code | | | Main contact number(s)<br>( )_____<br>( )_____<br>Email Address: |
| Employment status of person responsible for paying bill<br>□ **Employed** (date of hire):_____ □ **Unemployed** (how long unemployed:)_____<br>□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** _____ | | | |

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| **FAMILY INFORMATION** | | | | | |
|---|---|---|---|---|---|
| List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. **FAMILY SIZE** _____ *Attach additional page if needed* | | | | | |
| 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)- Income drawn from assets for example-stocks, bonds, IRAs, mutual funds, rental income, etc. | | | | | |

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| **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.**<br>**Examples of proof of income include:**<br>• A "W-2" withholding statement; or<br>• Current pay stubs (*3 months*); or<br>• Last year's income tax return, including schedules if applicable; or<br>• Written, signed statements from employers or others; or<br>• Statements of income drawn from assets (stocks, bonds, IRAs, mutual funds, etc); or<br>• Approval/denial of eligibility for unemployment compensation.<br>If you have no proof of income or no income, please attach an additional page with an explanation. |
| **EXPENSE INFORMATION** |
| *We use this information to get a more complete picture of your financial situation.* |
| Monthly Essential Living Expenses:<br>Rent/mortgage $_____ Medical expenses $_____<br>Medical Insurance Premiums $_____ Utilities $_____<br>Other Debt/Expenses $_____ (*child support, loans, medications, other*) |
| **ASSET INFORMATION** |
| *This information may only be used in accordance with our policy and the State regulations in which you received care and is collected and considered as required by the Centers for Medicare and Medicaid Services (CMS) for Medicare cost reporting.* |
| Current checking account balance $_____<br>Current savings account balance $_____<br>Does your family have these other assets? **Please check all that apply**<br>□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)<br>□ Property (excluding primary residence) □ Own a business |
| **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. |

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| PATIENT AGREEMENT | |
|---|---|
| I understand that Providence may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.<br><br>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.<br><br>_____ _____<br>Signature of Person Applying Date | |