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Effective	11/2000	Owner	Jana Symonds: Director of Revenue Cycle
Approved	N/A		
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Due For Review	1 year after approval		

Health Care Assistance Policy and Procedure

Purpose

The purpose of this policy is to provide guidelines for the determination of eligibility and for providing financial assistance for qualified individuals receiving emergency and medically necessary health care services from Mid Valley Hospital and Mid Valley Clinic (collectively "MVH") pursuant to its Charity Care and Indigent Care program also known as Health Care Assistance Program ("HAP").

Definitions

MVH's HAP Policy and definitions shall conform to the requirements as described in the Revised Code of Washington (RCW) 70.170, Washington Administrative Code (WAC) 246-453, 26 USC 501(r) of the Internal Revenue Code, and 26 CFR 1.501(r). The following definitions also apply to this policy.

Annual - Occurring once every year

Annual Income - A measure of a household's gross annual cash receipts before taxes derived from wages and salaries, welfare payments, social security payments, strike benefits, unemployment or disability payments, child support, alimony and net income from business and investment activities paid to the individual. The following income sources should also be factored into calculating total gross income: freelancing, side jobs, consulting, tips, self-employment, selling goods on on-line storefronts, selling items at a craft fair or similar venue, rental property income, interest/dividends or capital gains from investments, , royalties, oil/gas/mineral rights, gambling or lottery winnings, etc.

Catastrophic Charity Care - This means charity care for patients with family income in excess of 300 % of the federal poverty guidelines, but their circumstances indicate severe financial hardship or personal loss due to their medical debt to income.

Charity Care - 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 deductible or coinsurance amounts required by a third party payer based on the

criteria in this policy. Charity care is also referred to as Financial Assistance.

Director of Revenue Cycle - DRC

Family - Family is defined as a group of two or more persons related by birth, marriage or adoption, who live together; all such persons are considered members of one family. Adult children living with their parents will be considered their own guarantor.

Federal Poverty Guideline - **(FPG)** This means a poverty threshold issued by the U.S. Department of Health and Human Services (HHS) for administrative purposes, for example, determining financial eligibility for federal programs. FPG, like the Federal Poverty Level (FPL), varies by family size. However, elderly status is not considered in FPG calculations. Additionally, FPG is not uniform nationally: The 48 contiguous states and D.C. use the same FPG, while Alaska and Hawaii each have their own FPG.The poverty guidelines are updated periodically in the Federal Register by HHS under the authority of 42 U.S.C. 9902(2).

Federal Poverty Level - (FPL) An economic measure established by the HHS that is used to decide whether the annual income level of an individual or family qualifies them for certain federal benefits and programs. HHS updates it's poverty guidelines annually, illustrating the set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities, adjusting for inflation. The FPL is also referred to as the FPG in this HAP Policy.

The poverty definition is based on money income before taxes and does not include capital gains or non-cash benefits. The official FPL is calculated annually in order to reflect inflation by the Census Bureau and is used primarily for statistical purposes, for example, to estimate the number of Americans in poverty each year. The Census Bureau assigns each person or family a singular threshold out of a possible 48, which can vary by family size (designated up to a nine-person family unit or more), number of children, and in the case of one-person and two-person households, elderly status. The FPL is the same, however, for all 50 states and the District of Columbia (D.C.).

Fiscal Year - The IRS defines a fiscal year as 12 consecutive months, ending on the last day of any month (except December**).** It is defined herein as a calendar year or the same as the income tax filing year.

Health Care Assistance Program Application - HAPA

Income - Total cash receipts before taxes derived from wages, salaries, welfare/social security payments, strike payments, unemployment, disability benefits, child support/alimony and net earnings from business and investment activities paid to the individual**.**

Indigent Person - The term "indigent person" is defined as a patient or the patients guarantor, who qualifies for Charity Care or Financial Assistance based on the FPL, adjusted for family size and who has exhausted any Third Party Coverage in accordance with the law.

Liquid Assets - An asset in the form of money or cash in hand, or an asset which can be quickly converted into cash without losing much value. Real property is not considered a liquid asset.

Mid-Valley Hospital - MVH

Nominal charges - This is an unadjusted rate or change in value. In economics and finance, a nominal

change is a change in value that is unadjusted for inflation, seasonality, interest compounding, or other factors. Nominal values are expressed in terms of current prices or figures.

Patient Account Representative - PAR

Real Property - Fixed property or land, and buildings, structures and permanent improvements upon or attached to land.

Third Party Coverage - An obligation on the part of an insurance company, health care services contractor, health maintenance organization, group health plan, government program(Medicare, Medicaid or other assistance programs, workers compensation, veteran benefits) or health sharing ministry as defined in 26 U.S.C. Sec 5000A, 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 (for example, auto accidents or personal injuries) which have resulted in the medical condition for which the patient has received health care services.

Washington State Navigator - WSN

Applicability

This HAP Policy is applicable to medically necessary services. Discounts listed in the policy are determined in accordance with state law.

The policy applies to all patients, regardless of whether or not the patient is insured or uninsured.

Policy

This policy allows for partial or complete reduction of charges incurred for medically necessary medical services for eligible individuals as stated in this HAP Policy. The amount owed is considered for Charity Care when all other means have been exhausted and all benefits have been applied against the debt. The only amounts that will be included in such a reduction must be considered to be the patient's balance.

Mid Valley Hospital is committed to serve, without exclusion, and to provide appropriate hospital-based medical services to all persons in need of medical attention, regardless of ability to pay. Mid Valley Hospital's HAP offers free or discounted care to individuals who meet the established criteria. Medically necessary charges that exceed a patient's ability to pay and which are not covered by any third-party payment sources, including Medicare and Medicaid, shall be considered eligible for application to the HAP.

In order to protect the integrity of the operations and fulfill this commitment, the following criteria for the provisions of HAP have been established. These criteria will assist the staff in making consistent and objective decisions regarding eligibility for HAP, while ensuring the maintenance of a sound financial base.

Nominal fees are not applicable to MVH HAP Policy.

A sliding scale shall be used to determine the amount for Financial Assistance for the patient's or guarantor’s obligation with thresholds, which are adjusted for family size, as follows:

- Patient or his/her guarantor up to 200% FPG shall be deemed Charity Care eligible for the full amount of the patient's responsibility, and written off at 100%without a requirement of an asset test.
- Patient or his/her guarantor from 201% to 250% FPG will have a 75% discount for the full amount of the patient's responsibility and which may be reduced by amounts reasonably related to l a liquid asset test as stated herein. requirement of liquid assets.
- Patient or his/her guarantor from 251% to 300% FPG will have a 50% discount for the full amount of the patient's responsibility and which may be reduced by amounts reasonable related to a liquid asset test as stated herein.

A patient who exceeds 300% FPG but has medical debt in excess of 25% of annual income will be considered "Catastrophic Charity Care". The following sliding scale, which is adjusted for family size, shall be used to determine discounts for the full amount of the patient's responsibility, and written off as Charity Care:

- Medical Debt between 25% and 50% of annual income will be eligible for a 15% discount.
- Medical Debt between 50% and 75% of annual income will be eligible for a 30% discount.
- Medical Debt over 75% of annual income will be eligible for a 50% discount.

Charity Care or Financial Assistance may be awarded for patients who are uninsured, underinsured, ineligible for any government health care benefit program or who are otherwise unable to pay for their care based upon an eligibility determination in accordance with this HAP Policy.

The following services are eligible for Charity Care per WAC 246-453-010 (7) and section 501(r)(4) of the Internal Revenue Code: hospital based medical 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. These services expressly include emergency medical care for an emergency medical conditions(within the meaning of the Emergency Medical Treatment and Labor Act and Chapter 246-453-010 of the Washington Administrative Code) consistent with the emergency department's available capabilities, regardless of whether an individual is eligible for Financial Assistance.

MVH neither adopts nor maintains an admission practice or policy which results in the following:

(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 MVH.

When determining eligibility for Financial Assistance, MVH does not consider and will not discriminate based on disability, race, creed, color, national origin, age, ancestry, marital status, religion, domestic or civil status, military status, sexual orientation or lack there of, or any protected class or status into consideration.

The remaining balance after sliding scale application, shall be made in monthly installments (e.g., “Payment Plan”) with an agreed dollar amount, without interest or late fees, and due date for those payments to be made. Payment Plans will be made and offered in accordance with MVH's Self Pay Policy, which can be made available electronically or in paper upon request. The patient or guarantor’s account may be placed in collection with a collection agency for non-payment in accordance with MVH Bad Debt Accounts Collection Policy & Procedure. Individuals may request a copy of these Policies by contacting 509-826-7631.

Asset Policy

Asset testing cannot and will not be used to assess income for patients and families with annual incomes at or below 200% of the FPL.

Liquid assets will be considered for those applicants between 201% and 300% FPL or to the extent the law allows.

These assets will not be considered when determining a patient’s or guarantor’s eligibility for Charity Care:

- First $5000.00 in monetary assets for an individual or $8000.00 for a family of two, and an additional $1500 per family member. 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.
- Any equity in a primary residence.
- Retirements plans other than 401(k)
- Prepaid burial plots or prepaid burial contract
- Life insurance policies with a face value of$10,000 or less.
- One vehicle and second vehicle if needed for employment or medical purposes.
- Tools of the trade required to perform a job.

In the event that the responsible party is not able to provide any of the documentation described above, MVH shall rely upon a written and signed document from the responsible party supporting their claim of need or indigency in accordance with WAC 246-453-030(4).

Amounts Generally Billed

Amounts generally billed calculation (AGB) in accordance with the Patient Protection and Affordable Care Act (PPACA) if a patient receives charity care, MVH will not charge that patient more for emergency or other medically necessary care than the amounts generally billed (AGB) to insured patients. A patient eligible for charity care is considered to be "charged" on the amount he/she/they are personally responsible for paying, after discounts and insurance payments have been applied to the account relating to the episode of care.

Patients are eligible for pre-screening to determine if sponsorship is possible based on the current FPL adjusted for family size. This determination can be done pre-service or post service. Final charity care sponsorship will be determined within 14 days of the completed application being returned and all encounters eligible for charity care approval will be noted accordingly within the Electronic Health Record. Account adjustments will be applied to the when the amount becomes the patient's or guarantor's responsibility.

MVH elects to use the "Prospective Method" to determine AGB. Additionally, MVH elects to calculate AGB using Medicare fee-for-service (traditional Medicare, excluding Medicare Advantage) as a basis for determination. Under this method, MVHC will use the billing and coding process that would be normally used if the charity eligible patient were a Medicare fee-for service beneficiary. The AGB is calculated as the amount that Medicare would allow for the care (includes the amount Medicare would pay as well as any beneficiary responsibility such as co-payments, co-insurance and deductibles). If you have further questions regarding our basis for charges, please contact our DRC at 509-826-7638.

Communications to the Public

Notice shall be made publicly available through the posting of signs in public areas of the hospital and clinic, including admissions and/or registration, the emergency department, billing/financial services, that charges for services provided to those persons meeting the criteria established within WAC 246-453-040 may be waived or reduced. The Policy is available to anyone that wants it and is available on the website at https:\\www.mvhealth.org. Information will be assembled in an easy-to-read summary in both English and Spanish.

Charity Care forms, instructions and written applications shall be furnished to the responsible party when requested or otherwise requested from another party on behalf of the patient or when screening indicates potential need. A written notice is available in pamphlet, plain language flier, on the website as well as at the facility in hard copy. Applications can be sent and received through our website and/or through smart phone via link.

If for some reason the patient is not made aware of the existence of charity care before treatment such as in an emergency, he or she will be notified as soon as possible. All applications, whether initiated by the patient, their representative or an employee of MVH, should be accompanied by documentation to verify the information in the application. Information requests to verify assets are limited to information that is reasonable necessary and readily available, and may not be used to discourage applications.

A list of covered providers can be found at Financial Assistance – Mid-Valley Hospital.

- Services provided by and billed for by external facilities other than MVH do not qualify for our charity care policy such as Confluence Health and Family Health Center OB providers.
- When referred to an external facility by one of our providers, the care that is provided is not covered by our HAP Policy (Charity Care).
- When faced with a bill from an external facility or provider, please direct your inquires to that facility or provider as to their policy on financial assistance.

Procedure

Process for Determining Eligibility

An annual application for program consideration and eligibility may be filled out for each calendar year. The application and supporting documents should be returned within 2 weeks of receipt or communication with MVH to request additional time (2 weeks) to submit proper documentation.

Eligibility is based solely on the factors described above in the HAP Policy.

> Deceased patients will be verified by a certificate of death or death notice in the newspaper. Verification of no estate filed with county and/or a letter from the family indicating no estate exists IF family members can be located and will cooperate.

If a patient has qualified for Financial Assistance and continues to receive services for an extended period of time, MVH, at it's discretion, may require the responsible person to reapply if there is a change in a patient's financial circumstances or at the end of the fiscal year.

Timing of Income Determinations

Annual family income of the applicant will be determined as of the time the appropriate medically necessary medical services were provided, or at the time of application for health assistance and applicant demonstrates eligibility for assistance. Charity Care applies to both future care and past bills. It does not matter how old the bills are, or whether they have been sent to collections. If you are eligible, charity care can apply to your hospital bill.

> WAC 246-453-030 governs “initial determinations” and what hospital is required to rely upon.For the purpose of reaching an initial determination of sponsorship status, ho**spitals 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 purp**oses of the initial determination of sponsorship status**.

The following may be used by MVH to verify a patient’s or guarantor’s income for purposes of making a final determination of eligibility of Financial Assistance:

1. Pay stubs from employment during the relevant time period
2. Bank statement
3. Income tax returns for recent fiscal year or last tax return
4. W2 withholding statement
5. Forms approving or denying sponsorship of Medicaid and or other state funded medial assistance
6. Forms approving or denying unemployment benefits
7. Proof of Social Security Benefits
8. Letter from employer or welfare agencies

Guarantors of accounts must have disposal of income or accounts in order for it to be considered for

qualification, regardless of family status.

Consideration of Assets:

When determining eligibility for Financial Assistance under this HAP Policy for care received on or after July 1, 2022, for patients and/or guarantors not eligible for financial assistance for the full amount of hospital charges, Mid Valley Hospital may take into consideration the existence, availability, and value of assets of the patient and/or guarantor to reduce the amount of the discount granted. In doing so, Mid Valley Hospital will exclude from consideration certain assets described above under its Asset Policy.

With respect to those assets that may be taken into consideration, Mid Valley Hospital will seek only such information regarding assets as is reasonably necessary and readily available to determine the existence, availability, and value of such assets. Mid Valley Hospital will consider assets and collect information related to such assets as required by the Centers for Medicare and Medicaid (CMS) for Medicare cost reporting. Such information may include reporting of assets convertible to cash and unnecessary for the patient's daily living.

Duplicate forms of verification will not be requested. Only one current account statement is required to verify monetary assets.

If no documentation for an asset is available, a written and signed statement from the patient or guarantor is sufficient to making a final Financial Assistance eligibility determination.

Asset information will not be used for collection activities.

Catastrophic Health Assistance

A patient's or guarantor's eligibility for Catastrophic Health Assistances will be made on a case-by-case basis in accordance with this HAP Policy, and at the discretion of the DRC, pursuant to WAC 246-453-030(3) and WAC 246-453-030(4).

At time of admission or registration, admitting staff will offer the HAP Application (HAPA) to each patient or responsible party and indicate on the electronic form provided at time of registration whether the application was accepted or rejected. Meaning the patient was offered the application. Basic information and a paper copy of MVH's HAP Policy are available for patient consideration at that time.

All applications for consideration will be forwarded to the Patient Account Representative (PAR) on a daily basis. Processing the applications shall be the responsibility of the PAR.

All applications, whether initiated by the patient or hospital, for final determination of eligibility should be accompanied by documentation to verify income as indicated on the application form and as stated herein.

MVH will make reasonable efforts to determine the existence or nonexistence of Third Party Coverage for the services provided to the patient. Patients applying for Financial Assistance must make reasonable effort to exhaust all Third Party Coverage, including applying for or assisting MVH in applying for Third Party Coverage on the patient's behalf. If applicable for their income category, outlined in the statute. Patients or guarantors who fail to make reasonable efforts to cooperate with MVH's efforts to assist them in applying for such Third Party Coverage

may be the basis for MVH to deny Financial Assistance in accordance with RCW 70.170.060(5).

If patients are not eligible for Third Party Coverage for any reason, Mid Valley Hospital will still allow the patient or guarantor to apply for Financial Assistance pursuant to MVH HAP Policy.

In all cases, PAR will conduct a financial screening to determine if the patient is potentially eligible for State or Federal funding (example, Medicaid or SSI Medicare). If their medical history or personal status indicates potential benefits, the guarantor will be asked to apply for this funding before processing HAPA's. During this eligibility determination process for Financial Assistance in accordance with MVH's HAP Policy, all collection efforts will be ceased, in accordance with WAC 246-453-020(9)(b).

1. If information in our HAPA indicates that patients and their guarantor may be eligible for Third Party Coverage, Mid Valley Hospital will assist the patient and their guarantor in applying for coverage. Depending on the patients needs, our team will answer any questions, walk through any applications, and provide assistance linking them to any other resources they may need.
2. Mid Valley hospital has Navigators (WSN) on staff to help assist patient and family with their health care coverage needs, if they may qualify for Medicaid or managed care health coverage plans.
3. If the WSN finds that a patient and/or family will qualify for health coverage, they will assist them with an on-line application and walk them through the questionnaire process and/or assist in anyway possible.
4. The WSN will assist all patients and family with their questions or needs when it comes to applying for state insurance or assisting them with the insurance exchange to help purchase insurance.
5. It is Mid Valley Hospitals policy to screen all uninsured patients and pro-actively assist them towards better health-care opportunities through state or financial assistance funding. If any patient or family member has any Third Party Coverage needs, our PAR will assist them with their questions and/or HAP application needs.
    a. The guarantor will be asked to provide income verification documents within 30 days from the date the patient received the HAPA, 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 prior to receiving a final determination of sponsorship status. The failure of a responsible party to reasonably complete the appropriate application procedures shall be sufficient grounds for the hospital to initiate collection efforts directed at the patient.
    b. Using the above information, the PAR will evaluate the income information and, based on the patient's ability to pay at that time and with the Sliding Payment Scale, determine the amount of Charity Care or Financial Assistance if any that patient or guarantor is eligible to receive pursuant to this HAP Policy. Refer to sliding scale of this Policy.
    c. Upon receipt of all verification documentation from the patient or guarantor for final determination of eligibility, the PAR shall review and determine the percentage of the discount, make the appropriate adjustment using the appropriate transaction code, known as an alias, that corresponds with the General Ledger, and a work item will be

sent to the Director of Revenue Cycle (DRC) for review, approval or denial.

d. After review by the DRC the PAR will send written notice to the applicant of denial or approval within fourteen(14) calendar days of receiving information. If the application is denied Financial Assistance, the PAR will notify the patient, in writing, advising guarantor of the reason for the denial and also advising them of the appeal process.

e. On a monthly basis a report will be submitted to the Board of Commissioners for approval indicating the total dollars assigned to the HAP.

f. After determination of the HAPA, any financial obligation that is owed shall be payable in monthly installments in accordance with MVH Self Pay Policy, which is made available upon request. The responsible party will not be placed with a collection agency unless payment arrangements are in default and no satisfactory contact has been made with the responsible party. WAC 246-453-050(1)(c). Refer to MVH's Bad Debt Accounts Collection Policy and Procedure which is made available upon request.

Identification of HAP accounts during pre-collection activity responsibly: Patient Account Representative (PAR)

1. The PAR or Pre-collection company in the course of pre-collection activity, may identify potential HAP accounts. The PAR or Pre-collection company will send a Notice of HAP in the pre-collect letter to the patient's guarantor.
2. Upon receipt of the completed HAPA, follow guidelines as outlined above.

Health Care Assistance Program (HAP) approval authority levels & training

1. Applications will be approved on a daily basis by the PAR.
2. The Director of Revenue Cycle will review completed applications on an as needed basis.
3. The Board will be advised of the total applications and the total dollars written off as Charity Care.
4. MVH/MVC patient account representatives will receive yearly training in the Health Care Assistance Program to comply with state and federal laws as well as be an educated resource for our patients and their families.

Appeal Process

1. All HAP applicants will receive written notice of approving or denying Financial Assistance within fourteen (14) days of the HAP application in accordance with WAC 246-453-020. The written notification will include the appeals procedure that enables them to correct any deficiencies in documentation or request review of the denial by MVH's Chief Financial Officer for deciding the appeal.
2. Patients/Guarantor may appeal by writing a letter explaining why they feel the denial is inappropriate and or by supplying additional information to support a favorable decision.
3. Upon denial, the patient or guarantor shall be given thirty (30) days to appeal the decision.
4. Appeals should be directed to the CFO or the delegated staff member, who will meet with a

review committee and consider the appeal including all documentation and information submitted. MVH shall make a written determination within ten (10) business days from date of receipt and communicate that written decision to the patient or guarantor thereafter.

5. If the denial of Financial Assistance is upheld, 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.
6. MVH should make every reasonable effort to reach initial and final determinations of HAP designation in a timely manner; however, the hospital shall 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 two hundred percent of the federal poverty standard as adjusted for family size. The timing of reaching a final determination of HAP status shall have no bearing on the identification of HAP deductions from revenue as distinct from bad debts.
7. 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 HAP criteria at the time that services were provided, any payments in excess of the amount shall be refunded to the patient within thirty days of achieving the Financial Assistance eligibility designation.
8. **APPROVALS:** Director of Revenue Cycle, Chief Financial Officer and Administrator

All Revision Dates

02/2026, 07/2025, 10/2024, 10/2024, 10/2024, 04/2024, 11/2023, 01/2023, 08/2022, 06/2022, 09/2021, 05/2021, 11/2020, 10/2019, 10/2019, 03/2018, 04/2016, 01/2016, 05/2012, 04/2011, 05/2009, 01/2008

Attachments

- HAP-2026 Spanish sliding scale.xlsx
- HAP-2026-Updated-PGL-English (1).xlsx
- HAP-Application-English_Updated-12-16-2024.docx
- HAP-Application-Spanish_Updated-12-16-24.rtf

Approval Signatures

Step Description	Approver	Date
Policy Committee	Randy Coffell: CHRO	Pending

Holly Stanley: CFO	02/2026
Jana Symonds: Director of Revenue Cycle	02/2026