SUBJECT: Financial Assistance/Charity Care Policy	REFERENCE
DEPARTMENT: Patient Finance/Business Office Service of the District.	PAGE: 1 OF: 1
	EFFECTIVE:
APPROVED BY: Revenue Cycle Committee, Board of Commissioners.	REVISED: 03/31/2017

Model Plain Language Summary of Financial Assistance/Charity Care Policy

Garfield County Hospital District 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 Garfield County Hospital District we provide free care and financial assistance/charity care to eligible patients on a sliding fee scale basis, with discounts ranging from 100% to 201%.

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: 509-843-1591 ext. 146
- On our website at**: www.pomeroymd.com**
- In person: Garfield County Hospital District, Business Office, 66 North Sixth Street, Pomeroy, WA 99347. Paper applications can also be obtained at Pomeroy Medical Clinic, 446 Pataha Street, Pomeroy, WA 99347.
- To obtain documents via mail free of charge: Garfield County Hospital District, Attn: Business Office, 66 North Sixth Street, Pomeroy, WA 99347. Phone: 509-843-1591 ext. 146.

If English is Not Your First Language: Translated versions of the application form are available upon request from the Business Office at Garfield County Hospital District, 66 North Sixth Street, Pomeroy, WA 99347. Phone: 509-843-1591 ext 146

Other Assistance:

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 45 days from final bill. 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:Garfield County Hospital District 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.

Garfield County Hospital District
Financial Assistance Guidelines
2018 Federal Poverty Guidelines

SLIDING FEE SCALES

ANNUAL INCOME THRESHOLDS

		SLIDING SCALE DISCOUNTS				
		Pay 0%	Pay 25%	Pay 50%	Pay 75%	Pay 100%
POVERTY PERCENT		150%	175%	200%	225%	250%
Family Size = 1	$ 12,140.00	$ 18,210.00	$ 21,245.00	$ 24,280.00	$ 27,315.00	$ 30,350.00
Family Size = 2	$ 16,460.00	$ 24,690.00	$ 28,805.00	$ 32,920.00	$ 37,035.00	$ 41,150.00
Family Size = 3	$ 20,780.00	$ 31,170.00	$ 36,365.00	$ 41,560.00	$ 46,755.00	$ 51,950.00
Family Size = 4	$ 25,100.00	$ 37,650.00	$ 43,925.00	$ 50,200.00	$ 56,475.00	$ 62,750.00
Family Size = 5	$ 29,420.00	$ 44,130.00	$ 51,485.00	$ 58,840.00	$ 66,195.00	$ 73,550.00
Family Size = 6	$ 33,740.00	$ 50,610.00	$ 59,045.00	$ 67,480.00	$ 75,915.00	$ 84,350.00
Family Size = 7	$ 38,060.00	$ 57,090.00	$ 66,605.00	$ 76,120.00	$ 85,635.00	$ 95,150.00
Family Size = 8	$ 42,380.00	$ 63,570.00	$ 74,165.00	$ 84,760.00	$ 95,355.00	$ 105,950.00
Ea Additional Person, Add	$ 4,320.00					

MONTHLY INCOME THRESHOLDS

		SLIDING SCALE DISCOUNTS				
		Pay 0%	Pay 25%	Pay 50%	Pay 75%	Pay 100%
POVERTY PERCENT		150%	175%	200%	225%	250%
Family Size = 1		$ 1,517.50	$ 1,770.42	$ 2,023.33	$ 2,276.25	$ 2,529.17
Family Size = 2		$ 2,057.50	$ 2,400.42	$ 2,743.33	$ 3,086.25	$ 3,429.17
Family Size = 3		$ 2,597.50	$ 3,030.42	$ 3,463.33	$ 3,896.25	$ 4,329.17
Family Size = 4		$ 3,137.50	$ 3,660.42	$ 4,183.33	$ 4,706.25	$ 5,229.17
Family Size = 5		$ 3,677.50	$ 4,290.42	$ 4,903.33	$ 5,516.25	$ 6,129.17
Family Size = 6		$ 4,217.50	$ 4,920.42	$ 5,623.33	$ 6,326.25	$ 7,029.17
Family Size = 7		$ 4,757.50	$ 5,550.42	$ 6,343.33	$ 7,136.25	$ 7,929.17
Family Size = 8		$ 5,297.50	$ 6,180.42	$ 7,063.33	$ 7,946.25	$ 8,829.17

The Federal Register notice is at this link: https://www.federalregister.gov/documents/2018/01/18/2018-00814/annual-update-of-the-hhs-poverty-guidelines

Garfield County Hospital District
Caring for Generations

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

This application is for Financial Assistance at Garfield County Hospital District.

****THIS PAGE IS FOR YOUR RECORDS****

Financial Assistance is available to all Individuals, and families, who meet certain income requirements. You may qualify for 100% off your bill, or a partial percentage off your bill, even if you have Health Insurance. The state requires all hospitals to provide Financial Assistance. Garfield County Hospital District utilizes the Federal Poverty Guideline.

What does Financial Assistance Cover?

The Garfield County Hospital District Financial Assistance Program covers MEDICALLY NECESSARY Hospital and Clinic services, depending on your eligibility. Financial Assistance may not cover all health care costs, such as Co-Payments, and services provided by other organizations'.

If you have questions or need help completing this application:

Garfield County Hospital District Financial Services are available Monday through Friday from 8:00 AM to 5:00PM.

Excluding Holidays'

Lacey Gingerich (509)843-1591 EXT 146

In order for your Financial Application to be processed, you must:

- Provide information about all family currently living in your home.
- Provide Information about your family's GROSS MONTHLY INCOME, before deductions.
- Provide documentation of all family income and declare all assets.
- **SIGN** and **DATE** your Financial Assistance Application.
- Attach any other additional information if necessary.

NOTE: 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 state N/A. Not having a Social Security Number WILL NOT exclude you when applying for Financial Assistance.

You may continue to receive bills until we receive your completed Financial Assistance Application, with Supporting Documents.

Mail Completed Financial Assistance Application with Supporting Documentation to:

Garfield County Memorial Hospital
ATTN: Financial Services Lacey G
66 N. 6th Street
Pomeroy, WA 99347

● After we have received your Completed Application, with all Requested Documentation, we will contact you within 14 Business Calendar Days, if we are able to approve your Financial Application. By submitting a Financial Assistance Application, you are giving us your consent, to make necessary inquiries to confirm any and all information provided to us, on your Financial Assistance Application.

Garfield County Hospital District
Caring for Generations

FINANCIAL ASSISTANCE APPLICATION

INCOME INFORMATION

You must provide a minimum of TWO types of documentation,for proof of all income, for all family members listed, on your Financial Application. Examples include;

● W-2	● Last Year's Income Tax Return	● Letter of eligibility for Medicaid or State Funded Medical Assistance	● Workers Compensation Benefits
● Current Pay Stub	● 3 Months of Banks Statements	● Unemployment Benefits	● Social Security/SSI Benefits

● If you do not have income, you must fill out the Statement of Current Financial Situation, below.

ASSET INFORMATION

This information may be used, if your income is above 200% of Federal Poverty Guidelines

DOES YOUR FAMILY HAVE OTHER ASSETS? PLEASE CHECK ALL THAT APPLY

☐ Stocks ☐ 401K ☐ H.S.A ☐ BONDS ☐ Property (exclude primary residence)

☐ Trusts ☐ Own A Business If **YES**, please proved balance $_____

STATEMENT OF CURRENT FINANCIAL SITUATION

Please provide us with any other information about your current Financial Situation, that you would like for us to consider, such as financial hardship, job loss, temporary income, or personal loss. If you do not currently have income, you MUST explain how you are supporting your self.

ALL FAMILY MEMBERS' INCOME MUST BE DISCLOSED. IF YOU HAVE QUESTIONS ON THIS, PLEASE ASK!!!

APPLICANT AGREEMENT

I affirm that all the above listed information is true and correct, to the best of my knowledge. I also understand, if the information I have given, is determined to be inaccurate, the result will be an AUTOMATIC DENIAL FOR FINANCIAL ASSISTANCE, and I will be liable and expected to pay for all services provided.

SIGNATURE OF APPLICANT:_____ **DATE:**_____

Garfield County Hospital District
Caring for Generations

FINANCIAL ASSISTANCE APPLICATION

** PLEASE NOTE**

- **We can not guarantee you will qualify for Financial Assistance.**
- **When we receive your Financial Application, we will verify all information, and may ask for additional information, including verification of income.**
- **After we have received your Completed Application, with all Requested Documentation, we will contact you within 14 Business Calendar Days, if we are able to approve your Financial Application.**

PATIENT AND APPLICANT INFORMATION

PATIENT FIRST NAME	MIDDLE	PATIENT LAST NAME
BIRTH DATE	SOCIAL SECURITY NUMBER	
GUARANTOR FOR ACCOUNT	RELATION TO PATIENT	GUARANTOR SOCIAL SECURITY #
MAILING ADDRESS:		CONTACT CELL INFO

CITY:	STATE:	ZIP:	EMAIL:

EMPLOYMENT STATUS OF GUARNTOR:

☐ Employed ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Student ☐ Disabled
☐ Other:

FAMILY INFORMATION

List all family living in your household, this includes your self **Family Size___**

NAME	DOB	RELATION TO PATIENT	SOURCE OF INCOME (IF OVER 18)

ALL FAMILY MEMBERS' INCOME MUST BE DISCLOSED. IF YOU HAVE QUESTIONS ON THIS, PLEASE ASK!!!

SCREENING INFORMATION (OFFICE USE)

Has the pt. applied for Medicaid ? ☐ NO ☐ YES

***It may be required of you to apply, if you answered no, before you can be considered for Financial Assistance**

Is the pt. currently homeless? ☐ YES ☐ NO

Is the pt.'s medical related to a car accident or work injury? ☐ YES ☐ NO