POLICY STATEMENT

The policy of Island Health is to provide financial assistance consistent with the requirements of the Washington Administrative Code (WAC) Chapter 246-453 and Internal Revenue Code (IRC) Section 501(r).

PURPOSE

Island Health ("Hospital") is committed to the provision of medically necessary healthcare services to all persons in need of such services, without discrimination and regardless of whether they are eligible for financial assistance under this policy or through any other program. In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of financial assistance, consistent with the requirements of WAC, Chapter 246-453, and IRC Section 501(r), are established.

This policy will assist staff in making consistent objective decisions regarding eligibility for financial assistance while ensuring the maintenance of a sound financial base. This policy will allow Hospital to use its resources to most efficiently help those in need of healthcare services regardless of ability to pay.

Accordingly, this written policy:

- Includes eligibility criteria for financial assistance and whether such assistance includes free or discounted care;
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy;
- Describes the method by which patients may apply for financial assistance;
- Describes the actions that may be taken in the event of nonpayment of any remaining liability;
- Describes the information that may be obtained from sources other than the individual seeking financial assistance that Hospital may use to presumptively determine whether an individual is eligible for financial assistance, and under what circumstances such information may be used;
- Describes how Hospital will publicize the policy within the community served by Hospital; and
- Provides a list of providers, other than Hospital itself, delivering medically necessary care and specifies which providers are covered by this financial assistance policy.

SCOPE

Patient Accounts, Finance, Patient Access

DEFINITIONS

Financial assistance: Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Hospital's process for obtaining financial assistance or other forms of payment or financial assistance. In the event that a patient is not cooperative with the financial assistance application process, Hospital may initiate collection efforts against the patient for amounts owed. Patients are expected to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so.

Appropriate Hospital-Based Medical Services: Defined in WAC 246-453-010(7) as those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. For

purposes of this section, 'course of treatment' may include mere observation or, where appropriate, no treatment at all." This is also the definition of "medically necessary care" as used in this policy and attachments.

Emergency Medical Services: Services provided within Hospital to treat an emergency medical condition, which is defined in section 1867(e)(1) of the Social Security Act as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child."

Extraordinary Collection Actions: Especially aggressive efforts to encourage individuals to pay a liability, as defined in Reg. 1.501(r)-6(b). In general, extraordinary collection actions include selling a debt to another party; reporting adverse information about an individual to a consumer credit reporting agency or credit bureau; deferring or denying medically necessary care because of nonpayment of a previous liability; requiring payment before providing medically necessary care because of nonpayment of a previous liability; and actions that require a legal or judicial process (including liens, foreclosures, attachments, seizures, civil actions, arrests, writs of body attachment, and garnishments).

Amounts Generally Billed ("AGB") Limit: The average amount collected by Hospital for providing a emergency and other appropriate hospital-based medical services to individuals who have insurance covering that service, as defined in Reg. 1.501(r)-1(b)(1).

Gross Family Income: Annualized income of the patient and any immediate family members who reside with them, as determined by the acceptable documents and information identified in this policy rendered. "Family" is defined by WAC 246-453-010, paragraph 18 as a group of two or more persons related by birth, marriage, or adoption who live together. Annualized income means that an annual income is estimated based on the information for a shorter time period. Annualized income is calculated as of the date the services are rendered/provided, based upon documentation provided and upon verbal information provided by the patient. The calculation will take into consideration seasonal employment and temporary increases and/or decreases of income.

Responsible Party: An individual who is responsible for the payment of any hospital charges.

EQUIPMENT

Not applicable

QUALITY CONTROL

This policy will be reviewed annually.

I. SERVICES ELIGIBLE UNDER THIS POLICY

a. The following healthcare services are eligible for financial assistance:
   i. Emergency medical services provided anywhere in a hospital setting; and
   ii. Appropriate hospital-based medical services.
b. Purely elective procedures are ineligible for financial assistance.
c. See Attachment A for a list of providers who operate within Hospital. Attachment A identifies those providers whose services are eligible for financial assistance under this policy and those providers whose services are not eligible for financial assistance under this policy. Attachment A shall be updated at least quarterly to maintain accuracy.

II. ELIGIBILITY CRITERIA

a. Completed Application: Eligibility for financial assistance will be considered for individuals who submit a complete financial assistance application, as explained in Section III of this policy.
b. Other Medical Coverage: Financial assistance is generally secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare, Medicaid or medical assistance programs, other state, federal or military programs, or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.
c. Without Discrimination: The granting of financial assistance shall be based on an individualized determination of financial need of the patient at the time services are rendered and shall not consider age, gender, race, social or immigrant status, sexual orientation or religious affiliation.
d. Gross Family Income: In those situations where, appropriate primary payment sources are not available, patient shall be considered for financial assistance under this policy and within the requirements of WAC 246-453. All assets of the family as defined by WAC 246-453 are considered in determining the applicability of the fee scale in Attachment B. These assets include bank accounts, investment accounts, 401 (k) plans, trusts, business ownership, and real estate excluding the primary residence (rental properties, vacation home). Asset exclusions are detailed on Attachment F. Attachment B shall be updated annually to maintain accuracy.
   i. The full amount of Hospital's charges will be determined to be financial assistance for a patient with gross family income at or below 200% of the current federal poverty level.
   ii. 75% of Hospital's charges will be determined to be financial assistance for a patient with gross family income between 201% and 250% of the current federal poverty level, and 50% of Hospital's charges will be determined to be financial assistance for a patient with gross family income between 251% and 300% of the current federal poverty level. Hospital will review a patient's financial resources and assets for possible funding to pay for billing charges and may consider these factors when determining and appropriate level of financial assistance.
e. Disclosure of Assets: Hospital shall not require a disclosure of assets from financial assistance applicants whose income is at or below 200% of the current federal poverty level, but may require a disclosure of assets from applicants whose income is above 200% of the current federal poverty level.
f. Catastrophic Care: Hospital may offer catastrophic financial assistance, which means Hospital may write off amounts for patients with gross family income in excess of 300% of the federal poverty level if circumstances indicate severe financial hardship. All catastrophic financial assistance

write-offs shall be approved by the Chief Financial Officer upon recommendation by the Director of Revenue Cycle.

g. Eligibility on a completed application is valid for eligible services received within 60 days following the application approval date.

h. When an individual qualifies for financial assistance under this policy, the responsible party's remaining liability shall be calculated by multiplying the gross charges from the eligible care by 100% minus the appropriate financial assistance discount percentage.

i. When an individual is eligible for a financial assistance discount under this policy, the responsible party will be expected to provide payment over a reasonable period of time in accordance with Hospital's Financial Policy, without interest or late fees.

j. The responsible party's financial obligation remaining after the application of the financial assistance discount shall be payable as negotiated between Hospital and the responsible party within the terms of Hospital's Credit Policy.

III. PROCESS FOR APPLICATION

a. Hospital shall use an application process for determining eligibility for financial assistance. However, Hospital may presumptively determine an individual's eligibility for financial assistance under this policy without a completed application based on information in paragraph B.

b. Requests for financial assistance will be accepted from various sources, including physicians, community or religious groups, social services, financial services, personnel, and the patient. If Hospital has reason to believe an individual may qualify for Medicaid, Hospital will check Provider One, Washington State's Medicaid payment system, for eligibility for financial assistance. See Attachment E "Identification of Patients Eligible for Certain Third-Party Coverage" for additional information for patients and/or guarantors who may be eligible for health care through Washington medical assistance programs or the Washington Health Benefit Exchange. Local law enforcement officials may provide information about the homeless status of an individual.

c. For the purpose of reaching an initial determination of financial assistance sponsorship status, Hospital shall rely upon information provided orally by a patient. Hospital may require the patient to sign a statement attesting to the accuracy of the information provided to Hospital for purposes of the initial determination of sponsorship status.

d. When submitted for consideration, a financial assistance application shall be accompanied by one of the following types of documentation for purposes of verifying income:

   i. W-2 withholding statements for all employment for the most recent 3 months for all household members;
   ii. Payroll check stubs from all employment during the relevant time period;
   iii. Last year's income tax return, including schedules if applicable;
   iv. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance;
   v. Forms approving or denying unemployment compensation;
   vi. Written statements from employers or welfare agencies; or

   In the event that the responsible party is not able to provide any of the documentation provided above, Hospital shall rely upon written and signed statements from the responsible party for making a final determination of eligibility for financial assistance.

e. Hospital may require proof of the value of assets for applicants whose income is above 200% of the current federal poverty level. See Attachment F for Consideration of Assets.

f. Completed applications and documentation should be submitted to Island Health Patient Accounts. Acceptable methods of submission include:
   i. Mail to "Attention: Patient Accounts", 1211 24th Street, Anacortes, WA 98221
   ii. Deliver in-person to any Island Health personnel at 1211 24th Street, Anacortes, WA 98221. Label the package "Attention: Patient Accounts".
   iii. Fax to (360) 299-1369, "Attention: Patient Accounts"

g. If a responsible party submits an incomplete financial assistance application, Hospital shall take the following steps to encourage them to complete the application.
   i. Suspend any extraordinary collection actions to obtain payment for the care.
   ii. Provide a written notice to the responsible party that describes the additional information and/or documentation that must be submitted before the application will be considered. This notice shall also include the contact information indicated in Section VI, paragraph A of this policy.
   iii. Allow a reasonable amount of time for the responsible party to submit a complete financial assistance application. Such period of time shall be at least 14 days from the date the written notice is sent to the responsible party.

   If the responsible party fails to provide the requested information within the stated time, Hospital may renew the previously initiated extraordinary collection actions.

h. If Hospital uses information provided by any party other than the responsible party to determine that a responsible party is eligible for a 50% or 75% discount under this financial assistance policy, Hospital shall take the following steps.
   i. Notify the responsible party, in writing, regarding the basis for this determination, including the information used and the source of that information.
   ii. Inform the responsible party that they may be eligible for a 100% discount under this financial assistance policy if the responsible party submits a complete financial assistance application and other supporting documentation.
   iii. Allow a reasonable amount of time for the responsible party to submit a complete financial assistance application. Such period of time shall be at least 14 days from the date the written notice is sent to the responsible party.
   iv. If the responsible party submits a complete financial assistance application, Hospital shall follow all aspects of this policy in determining the responsible party's eligibility for financial assistance.

IV. PROCESS FOR ELIGIBILITY DETERMINATION

a. The initial determination of eligibility shall be completed at the time of admission or as soon as possible following services to the patient. Pending final eligibility determination, Hospital will not initiate collection efforts or requests for deposits, provided that the responsible party is cooperative with Hospital's efforts to reach a determination of sponsorship status, including return of applications and documentation within 14 days.

b. Designations of financial assistance, while generally determined at time of admission, may occur at any time upon learning of facts that would indicate eligibility.

c. Following the initial request for financial assistance, Hospital may pursue other sources of funding, including Medicaid. Hospital may delay processing a financial assistance application until after the individual's Medicaid eligibility has been determined.

d. All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form. Documents pertaining to financial assistance shall be retained for 5 years.
e. Hospital will make a final eligibility determination and will notify the responsible party within 14 days of receipt of a completed financial assistance application and all necessary supporting documentation.
f. If an individual is determined to be eligible for a 50% or 75% discount, Hospital will provide the individual with a billing statement that indicates the remaining amount the individual owes, how that amount was determined, and how the individual can obtain information about the current AGB limit.
g. In the event Hospital denies an individual's application for financial assistance, Hospital shall notify the individual of the denial and the basis for the denial.
h. All patients denied financial assistance shall be provided with, and notified of, Hospital's appeals procedure, which enables a patient to correct any deficiencies in the documentation or request review of the denial and results in review of the determination by Hospital's Chief Financial Officer or equivalent.
i. In the event that Hospital's final decision upon appeal affirms the previous denial of financial assistance, the responsible party shall be notified in writing of the decision and the basis for the decision.

V. PROCESS FOR AMOUNTS GENERALLY BILLED

a. An individual who is determined to be eligible for financial assistance under this policy shall not be required to pay more for emergency medical care and other appropriate hospital-based medical services than the amounts generally billed to individuals who have insurance covering such care.
b. This AGB limit shall be used by Hospital to determine the maximum amount that an individual may be liable to pay after such individual is determined to be eligible for financial assistance under this policy.
c. Hospital shall use the "look-back method" as described in Regulation 1.501(r)-5(b)(3).
d. Hospital shall calculate a new AGB limit at least annually.
e. Hospital shall implement the new AGB limit within 120 days of the end of the 12-month period used for the look-back method calculation.
f. Attachment C contains information about the currently applicable AGB limit and how it was calculated.

VI. PROCESS FOR COMMUNICATION

a. The Patient Accounts department at Island Health shall provide information about this financial assistance policy and/or provide assistance with the financial assistance application process. Patient Accounts is located at 1211 24th Street, Anacortes, WA 98221 and is available by phone at (360) 299-1378.
b. Hospital shall notify and inform individuals about the availability of financial assistance in the following ways.
    i. Financial agreement forms will state that financial responsibility is waived or reduced if the patient is determined to be eligible for financial assistance.

ii. Hospital shall set up conspicuous public displays that notify and inform patients about the financial assistance program. Such displays shall be located in the emergency room and all admissions areas. Such displays shall include the following information.
    1. Financial assistance is available under Hospital's financial assistance policy.
    2. Information about how or where to obtain information about the financial assistance policy and application process.
    3. Information about how or where to obtain copies of this financial assistance policy, a plain language summary of this financial assistance policy, and the financial assistance application.

iii. Hospital shall offer a paper copy of the plain language summary of this financial assistance policy to patients as part of the intake and/or discharge process.

iv. Hospital shall include the following information on all billing statements.
    1. Financial assistance is available under Hospital's financial assistance policy.
    2. The telephone number of a Hospital office or department that can provide information about the financial assistance policy and process.
    3. The direct web site address (URL) on which this financial assistance policy, a plain language summary of this financial assistance policy, and the financial assistance application are available.

    The written notice on billing statements shall be conspicuously placed and of sufficient size to be clearly readable.

v. This financial assistance policy, a plain language summary of this financial assistance policy, and the financial assistance application shall be available at all times on Hospital's website.

vi. Paper copies of this financial assistance policy, a plain language summary of this financial assistance policy, and the financial assistance application shall be made available upon request and without charge. These paper copies shall be available by mail, in Hospital's emergency room, and in all admissions areas to Hospital.

vii. Hospital shall take reasonable efforts to notify and inform members of the community about this financial assistance policy in a manner that is reasonably calculated to reach those community members who are most likely to need financial assistance from Hospital.

viii. If any population with limited English proficiency comprises more than 5% of the population in Hospital's community or more than 1,000 individuals, then all communication methods described here shall also be provided in the primary language of that population.

VII. PROCESS FOR COLLECTIONS

a. See Attachment D for a list of actions that may be used by Hospital to collect liabilities from individuals, including extraordinary collection actions. Attachment D also provides a general timeframe for these actions.

b. Island Health prohibits the use of all extraordinary collection actions against individuals other than the actions listed in Attachment D. This prohibition applies to Island Health and to all other parties acting on behalf of Island Health.

c. If an individual submits a financial assistance application, Hospital shall cease all collection efforts until a determination of financial assistance eligibility is made.

d. If Hospital learns that an individual has filed an appeal related to the denial of financial assistance, Hospital shall cease all collection efforts until the appeal is finalized.

e. If Hospital or another authorized party has already begun an extraordinary collection action against an individual when that individual submits a complete financial assistance application, the extraordinary collection action shall be suspended. Suspending an action means that no new extraordinary collection actions are initiated and no further steps are taken on a previously existing extraordinary collection action. This suspension may be lifted when Hospital determines the individual's eligibility for financial assistance and notifies the individual as prescribed in Section IV, paragraphs E – G of this policy.

f. If Hospital or another authorized party has already begun an extraordinary collection action against an individual when that individual is determined to be eligible for financial assistance under this policy, Hospital and/or the other authorized party shall take all reasonably available measures to reverse the extraordinary collection action. Such steps include, but are not limited to, measures to vacate any judgment against the individual, lift any levy or lien on the individual's property, and remove from the individual's credit report any adverse information that was reported.

g. Island Health shall not take any extraordinary collection actions against an individual for an episode of care within 120 days of the date the first post-discharge billing statement is sent to the individual.

h. At Hospital's discretion, a single collection action may be taken to obtain payment for multiple episodes of care. However, in such situations, an extraordinary collection action shall not be taken within 120 days of sending the first post-discharge billing statement for the most recent episode of care included in the extraordinary collection action and within 30 days of sending the final notice to inform the individual of collection actions that may be taken.

i. At least 30 days prior to taking any extraordinary collection action against an individual to obtain payment for an episode of care, Hospital or its agent shall provide the individual with a written notice that includes the following information.

    i. Financial assistance is available for eligible individuals.
    ii. The extraordinary collection actions that Hospital, or another authorized third party, intends to initiate against the individual to obtain payment for the care.
    iii. A deadline after which such extraordinary collection actions may be initiated.

    The written notice shall include a copy of the plain language summary of this financial assistance policy. Hospital or another authorized third party shall also make reasonable efforts to orally notify the responsible party about this financial assistance policy and how the individual may obtain assistance with the financial assistance application process.

j. The Patient Accounts department shall have the final authority and responsibility to determine whether Hospital has made reasonable efforts to determine whether an individual is eligible for financial assistance under this policy and may therefore engage in extraordinary collection actions against that individual.

k. If an individual has made partial payment, and the individual is subsequently determined to qualify for financial assistance under this policy, any payments in excess of their newly calculated remaining liability shall be refunded to the patient within 30 days of the financial assistance eligibility determination.

ATTACHMENT A

Providers That Operate Within Island Health

Medical service expenses for a patient can generally be categorized as either hospital fees or provider (i.e. physician) fees. All hospital fees for emergency medical care and other appropriate hospital-based medical care are eligible for financial assistance under this policy. However, not all provider fees are eligible for financial assistance under this policy.

Island Health defines a "provider" as a physician or similarly credentialed individual. Providers do not include nurses or technicians.

All services provided by the following providers **are covered** by Island Health's Financial Assistance Policy.

- Island Primary Care – M Ave
- Island Walk-In Clinic – M Ave
- Island Primary Care – 24th Street
- Island Obstetrics & Gynecology – 24th Street
- Island Primary Care – Orcas
- Island Emergency Physicians / NW Emergency Physicians of Team Health
- Island Cancer Care
- Island Psychiatry & Behavioral Health
- Island Pulmonology
- Island Sports and Spine
- Island Surgeons
- Island Urology
- Island Wound Care & Hyperbaric Medicine

Services provided by the following providers **are not covered** by Island Health's Financial Assistance Policy.

- Cascade Facial Surgery & Aesthetics, PPLC
- Family Foot & Ankle
- Island Eye Physicians & Surgeons
- The Everett Clinic
- Mt. Vernon Birth Center
- Naval Health Clinic Oak Harbor
- North Sound Oral & Facial Surgery
- Pacific Pathology Partners
- Pacific Rim Urology
- Playhouse Dental
- Proliance Surgeons Cascade ENT
- Rosario Skin Clinic
- San Juan Rehab & Care Center
- Skagit Radiology
- Skagit Northwest Orthopedic
- Skagit Regional Health
- Whidbey Medical
- Cloud Healthcare LLC
- Western Washington Medical Group
- Mark Stivers, DDS
- John Gossom, MD
- Robert Lycksell, MD
- David Russell, MD
- Kenneth Bakken, DO
- Friedrich Loura, MD
- Chia-Jen Kuan, MD, PhD
- Frank Traficante, DDS
- Donald Wortham, MD
- Deborah Amos, MD
- Regina Currier, DPM
- Somnia Anesthesia
- Island Family Physicians/Family Care Network

Last updated: 01/24/2024

ATTACHMENT B

Island Health Financial Assistance Percentage Fee Scale

Household/Family Size	100% of Federal Poverty Level	200% of Federal Poverty Level	201-250% of Federal Poverty Level	251-300% of Federal Poverty Level
1	15,060.00	30,120.00	37,650.00	45,180.00
2	20,440.00	40,880.00	51,100.00	61,320.00
3	25,820.00	51,640.00	64,550.00	77,460.00
4	31,200.00	62,400.00	78,000.00	93,600.00
5	36,580.00	73,160.00	91,450.00	109,740.00
6	41,960.00	83,920.00	104,900.00	125,880.00
7	47,340.00	94,680.00	118,350.00	142,020.00
8	52,720.00	105,440.00	131,800.00	158,160.00
Discount if under:		100%	75%	50%

For family units of more than 8 members, add $5,380 for each additional member to determine 100% of Federal Poverty Level.

This table is published annually in the Federal Register by the U.S. Department of Health and Human Services. This table is applicable for calendar year 2024. The table is available online at http://aspe.hhs.gov/poverty-guidelines.

Financial assistance Discounts:

The full amount of Island Health's charges will be written off as financial assistance for a patient with gross family income at or below 200% of the current federal poverty level. These individuals will receive a 100% discount and will have no remaining liability related to covered medical care.

75% of Island Health's charges will be written off as financial assistance for a patient with gross family income between 201% and 250% of the current federal poverty level. These individuals, or any other responsible party, are required to pay the remaining 25% of their liability related to covered medical care.

50% of Island Health's charges will be written off as financial assistance for a patient with gross family income between 251% and 300% of the current federal poverty level. These individuals, or any other responsible party, are required to pay the remaining 50% of their liability related to covered medical care.

ATTACHMENT C

Island Health Amounts Generally Billed Calculation and Information

Island Health uses the "look-back method" as defined in Reg. 1.501(r)-5(b)(3) to calculate the amount generally billed ("AGB") to individuals who have insurance covering medically necessary care. An individual who is determined to be eligible for financial assistance under this policy shall not be required to pay more than the amounts generally billed to individuals who have insurance covering such care.

Island Health calculates a single AGB limit to apply to all individuals who qualify for financial assistance. The AGB limit currently in effect is 39.0%.

The AGB limit was calculated using the following formula.

$$\frac{\text{Total Allowed Claims and Other Payments}}{\text{Gross Charges}}$$

In the AGB calculation, "Total Allowed Claims" are those claims that have been submitted by Island Health and were allowed by Medicare fee-for-service and all private health insurers over a specified 12-month period. The calculation is not based on the date the service was provided to the individual or on the date the claim was paid. Island Health uses all claims for medical care in this calculation, rather than just those allowed for emergency and other appropriate hospital-based medical services.

"Other payments" are co-payments, co-insurance, deductibles, and any other payments made in relation to a claim included in Total Allowed Claims.

"Gross charges" are the total charges of the services for those claims included in Total Allowed Claims.

Island Health's most recent calculation of the AGB limit was for the period that began September 1, 2022, and ended August 31, 2023.

AGB limit calculated by: Director of Finance Megan Wood

Reviewed and approved by: CFO Julie Stewart

Last Updated: 12/28/2023

ATTACHMENT D

Island Health Collection Actions

This attachment identifies the actions taken by Island Health to encourage patients and other responsible parties to pay a liability owed to Island Health for the provision of appropriate hospital-based medical care, including extraordinary collection actions. It also identifies the general timeline used by Island Health in taking these actions.

- Island Health sends a billing statement upon determining the remaining balance after any insurance. This is referred to as the "first post-discharge billing statement".
- Approximately 30 days later, a second billing statement is sent.
- Approximately 30 days later, a third billing statement is sent.
- Between 14 and 30 days later, a letter is sent with "notice of debt and possible referral for collection given".
- After a minimum of 120 days after the first post-discharge bill, the account is sent to a collection agency.
- Accounts referred for collection are subject to RCW 19.16.50 which allows for governmental entities using a collection agency to add a reasonable fee, payable by the debtor, to the outstanding debt for the collection agency fee incurred or to be incurred. The current fee is 25%.
- While this account is with the collection agency, collection efforts include attempts to contact through USPS mail, telephone calls, and electronic communication when consumer has consented.
- Accounts eligible for credit reporting will be reported under applicable laws and regulations.
- The collection agency may commence with legal action. Island Health limits allowable legal actions to lawsuits, liens, and garnishments.

While this timeline is generally accurate, any step may fluctuate by a few days. However, in no event shall Island Health or an authorized third party take any extraordinary collection actions within 120 days of sending the first post-discharge billing statement to a responsible party.

Island Health prohibits the use of all extraordinary collection actions other than the actions listed here. This prohibition applies to Island Health and to all other parties acting on behalf of Island Health.

Attachment E
Identification of Patients Eligible for Certain Third-Party Coverage

For services provided to patients on or after July 1, 2022, the following procedures will apply for identifying patients and/or their guarantors who may be eligible for health care coverage through Washington medical assistance programs (e.g., Apple Health) or the Washington Health Benefit Exchange:

1. As a part of the charity care application process for determining eligibility for financial assistance and charity care, HOSPITAL will query as to whether a patient or their guarantor meets the criteria for health care coverage under medical assistance programs under chapter 74.09 RCW or the Washington Health Benefit Exchange.

2. If information in the application indicates that the patient or their guarantor is eligible for coverage, HOSPITAL will assist the patient or their guarantor in applying by, among other things, providing the patient or their guarantor with information about the necessary forms that must be completed or connecting them with other individuals (In house “In Person Assisters”) or agencies who can assist.
    a. When providing assistance to the application process, HOSPITAL will take into account any physical, mental, intellectual, sensory deficiencies or language barriers, which may hinder either the patient or their guarantor from complying with the application procedures and will not impose procedures on the patient or guarantor that would constitute an unreasonable burden.

3. If the patient or guarantor fails to make reasonable efforts to cooperate with HOSPITAL in applying for coverage under chapter 74.09 RCW or the Washington Health Benefit Exchange, HOSPITAL is not obligated to provide charity care to such patient.

4. If a patient or their guarantor is obviously or categorically ineligible or has been deemed ineligible for coverage through medical assistance programs under chapter 74.09 RCW or the Washington Health Benefit Exchange in the prior 12 months, HOSPITAL will not require the patient or their guarantor to apply for such coverage.

Attachment F
Consideration of Assets

When determining eligibility for financial assistance and charity care under this policy for care received on or after July 1, 2022, for patients and/or guarantors not eligible for charity care for the full amount of hospital charges, HOSPITAL may take into consideration the existence, availability, and value of assets for the patient and/or guarantor to reduce the amount of the discount granted. In doing so, HOSPITAL will *exclude* from consideration:

- The first $5000 in monetary assets for an individual, $8000 for a family of two, and $1500 of monetary assets for each additional 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;
- Equity in a primary residence;
- Retirement plans other than 401(k) plans;
- One motor vehicle (and a second motor vehicle if it is necessary for employment or medical purposes);
- Prepaid burial contracts or burial plots; and
- Life insurance policies with a face value of $10,000 or less.

With respect to those assets that *may be taken into consideration*, 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.

1. 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.
    a. Such information may include reporting of assets convertible to cash and unnecessary for the patient's daily living.

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

3. If no documentation for an asset is available, a written and signed statement from the patient or guarantor is sufficient.