Wallowa Memorial Hospital
& Medical Clinics

Financial Assistance Policy

Philosophy: Wallowa Memorial Hospital provides emergency and other medically necessary care, without discrimination, to all individuals regardless of their ability to pay, in accordance with the Emergency Medical Treatment and Labor Act (EMTALA) and applicable state and federal regulations. The Hospital is committed to granting Financial Assistance to eligible patients who are unable to pay for treatment and services. This policy is intended to comply with all federal, state, and local laws and regulations, including but not limited to Internal Revenue Code §501(r) requirements for tax-exempt hospitals. If a regulation conflicts with this policy, the applicable regulation will prevail.

Policy: These guidelines will be applied consistently in reviewing and approving applications for Financial Assistance for patients unable to pay. Any self-pay or uninsured patient who expresses an inability to pay will be offered a Financial Assistance application, and any insured patient who expresses an inability to pay their deductible, co-insurance, or co-payment may also be offered an application. Hospital staff must provide information about the Financial Assistance Policy (FAP) and a Plain Language Summary (PLS) in accordance with applicable federal and state requirements.

Application Period: The application period begins on the date care is provided and ends on the 240th day after the patient is provided with the first post-discharge billing statement for that care.

Eligibility Requirements: Eligibility for Financial Assistance will be determined using the most current Federal Poverty Level (FPL) guidelines, adjusted for household/family size.

- Household is defined as a single individual; spouses, domestic partners, or a parent and child under 18 years of age living together; and any other individuals for whom the single individual, spouse, domestic partner, or parent is financially responsible.
- Income means total cash receipts before taxes from wages, salaries, benefits, pensions, unemployment or disability compensation, Social Security, alimony, child support, investment earnings, and other monetary sources. Noncash benefits and public aid such as SNAP or housing subsidies are excluded. This definition aligns with Oregon's FAP policy requirements under ORS 442.614.
- Medically Necessary means health care services or supplies provided to prevent, diagnose, or treat an illness, injury, condition, or disease, and that meet generally accepted standards of medical practice. Determination of medical necessity may reference the Oregon Health Plan's List of Prioritized Health Services, when applicable. Medically necessary care does not include cosmetic procedures, experimental treatments, or services that are not reasonably expected to improve the patient's health outcome.

- Patient Cost means the amount a patient is personally responsible to pay for care after all payments from insurance or publicly funded health care programs have been applied. In accordance with Internal Revenue Code §501(r)(5), the Hospital does not bill gross charges and limits amounts charged for emergency or other medically necessary care to patients eligible for financial assistance to no more than the amounts generally billed (AGB) to patients who have insurance coverage for such care.
- Medical Debt means any balance a patient owes for medically necessary services or supplies after insurance payments, discounts, or financial assistance have been applied.
- A sliding scale is used to determine the level of discount for patients whose gross family income is between 200% and 400% of the Federal Poverty Level (FPL). Discounts are applied to the patient's responsibility after all applicable insurance or public program payments have been made. aspe.hhs.gov/poverty-guidelines

Family Income as a % of FPL	% Discount
0% - 200%	100% of Patient responsibility
200% - 300%	75% of Patient responsibility
300% - 350%	50% of Patient responsibility
350% - 400%	25% of Patient responsibility

- No patient who qualifies for financial assistance will be personally responsible for paying more for emergency or other medically necessary care than the Amounts Generally Billed (AGB) to individuals who have insurance covering such care, in compliance with Internal Revenue Code §501(r)(5).
- As a condition of receiving financial assistance, patients must:
    - Respond promptly to requests from their insurer for information necessary to process and adjudicate any claims for reimbursement.
    - Provide complete and accurate information about any potential third-party liability for the cost of services, including, but not limited to, coordination of benefits between multiple insurers covering the patient's care, accident reports, or workers' compensation claims or benefits

Prescreening and Presumptive Eligibility: In accordance with Oregon House Bill 3320 and this policy, the Hospital will identify patients who may qualify for financial assistance without requiring them to complete a full application when there is sufficient information to reasonably determine eligibility.

Prescreening Requirement: Prior to issuing any billing statement, the Hospital will automatically conduct a prescreening for the following patients:

- Uninsured.
- Enrolled in a state medical assistance program.

- Owing $500 or more after insurance payments have been applied.

Prescreening will be performed without requiring documentation from the patient and will not affect the patient's credit score. If a patient is determined eligible through prescreening, the Hospital will apply the financial assistance discount or adjustment before sending the first billing statement.

Presumptive Eligibility: The Hospital may also grant financial assistance based on other factors that reasonably indicate financial need, including but not limited to:

- The patient is deceased with no estate.
- The patient is mentally or physically incapacitated and has no representative to act on their behalf.
- The patient is enrolled in the Women, Infants, and Children (WIC) Nutrition Program.
- The patient is enrolled in the Supplemental Nutrition Assistance Program (SNAP).
- The patient is presumed eligible for Medicaid under Medicaid presumptive eligibility guidelines.
- The Hospital has evidence from an independent third-party agency that the patient's family income is at or below 200% of the Federal Poverty Level (FPL).

Patients will be notified in writing of prescreening or presumptive eligibility results, including an explanation of any financial assistance applied and instructions on how to submit a full financial assistance application if additional assistance may be available.

Catastrophic Medical Expenses: The Hospital may, at its discretion, grant Financial Assistance in the event of catastrophic medical expenses. These cases will be reviewed individually.

Covered Providers: This FAP applies to the following:

- Wallowa Memorial Hospital
- Wallowa Memorial Medical Clinics
- Emergency services provided by hospital employed or contracted providers that are covered under this policy

Non-Covered Providers: Some practitioners who provide care at Wallowa Memorial Hospital are independent and bill separately for their services, and are not covered under this FAP. A list of non-covered providers will be posted on the Hospital's website in a prominent location alongside this policy and available in paper form upon request at the Hospital's Registration, Billing, or clinic locations. As participation in financial assistance programs may vary among independent providers, patients should verify a provider's status prior to receiving services, as charges from non-covered providers are the patient's responsibility and are not eligible for discounts or adjustments under this policy.

How to Apply for Financial Assistance:

Application Access: Patients may obtain a Financial Assistance Application, PLS, FAP in the following ways:

- Download from the Hospital's website at wchcd.org.
- Pick up in person at the Hospital's Registration, Billing, or any clinic location.
- Request by phone at 541-426-5304 to have an application mailed.
- Receive notice of the availability of financial assistance in each billing statement.

In accordance with ORS 442.614 and Internal Revenue Code §501(r)(4), the Hospital will post the FAP, Financial Assistance Application, and PLS in conspicuous public locations within the Hospital, including the Emergency Department, Registration areas, and main entrances. Signage and materials will be provided in English, and in other languages if required by applicable state or federal law. Free paper copies will be provided to any member of the public upon request, without charge.

The Hospital will make reasonable efforts to identify patients who may be eligible for financial assistance and will offer information about the application process at discharge and during billing follow-up.

Required Documentation: All pages of the application must be completed and submitted with:

- Proof of income (e.g., W-2, payroll stubs).
- Most recent filed federal income tax return (Form 1040).
- Bank statements for the last three months for all accounts held by the household.

All information provided will be kept confidential. Completed applications and documentation should be submitted to the Hospital Business Office, 601 Medical Parkway, Enterprise, OR 97828 The Hospital will determine a patient's eligibility for financial assistance, upon request or as required by law, before transferring any unpaid charges to a debt collector or referring unpaid amounts to an external collection agency.

Notification Period: The notification period begins on the date care is provided and ends 120 days after the date of the first post-discharge billing statement. This period ends earlier if the Hospital receives a completed financial assistance application. If a completed application is not received by the end of the notification period, the Hospital may initiate extraordinary collection actions.

During the notification period, the Hospital will:

- Provide a PLS at registration or before discharge.
- Make reasonable efforts to orally notify patients about financial assistance and how to apply.

- Include a conspicuous notice on all billing statements with the phone number and website to obtain the FAP, Financial Assistance Application, PLS.
- Provide written notice at least 30 days before the end of the period with the application deadline, how to apply, the possible collection actions, and a copy of the PLS.

Application Period: The application period begins on the date care is provided and ends 240 days after the date of the first post-discharge billing statement. If a complete or incomplete financial assistance application is received during this period, the Hospital will suspend all extraordinary collection actions until the application is processed. If the application is incomplete, the Hospital will send a written notice specifying the additional information required and stating that if the completed application is not received by the end of the application period, specific collection actions may be taken; this notice will be provided at least 30 days before the end of the application period.

Billing Procedures: The Hospital will not initiate any extraordinary collection actions until after the third billing statement and only in compliance with applicable state and federal requirements.

If a completed Financial Assistance Application is received during the application period:

- All extraordinary collection actions will be suspended.
- A determination of eligibility will be made.
- The applicant will be notified in writing of the determination and the basis for the decision.

If an incomplete Financial Assistance Application is received during the application period:

- All extraordinary collection actions will be suspended.
- The Hospital will send written notice describing the additional information or documentation required to complete the application.
- The Hospital will provide written notice describing the specific collection actions that may be taken if a completed application is not received.
- This notice will be sent at least 30 days before the end of the application period.

Extraordinary Collection Actions: Extraordinary collection actions include, but are not limited to:

- Filing a civil lawsuit against an individual.
- Placing a lien on an individual's property.
- Garnishing wages or bank accounts.

The Hospital will not engage in any ECA before making reasonable efforts to determine whether the patient is eligible for financial assistance, as required by federal and state law.

Amounts Generally Billed (AGB) Discount: The Hospital uses the look-back method to calculate the AGB, based on actual claims paid to the Hospital by Medicare fee-for-service and private health insurers over a prior 12-month period, divided by the associated gross charges. Patients eligible for financial assistance will not be charged more than the AGB for emergency or other medically necessary care. The current AGB percentage and calculation methodology are available upon request.

Patient Responsibility after Financial Assistance: If a patient is approved for Financial Assistance and remains responsible for a portion of the bill, the patient will not be charged more for emergency or other medically necessary care than the applicable Amounts Generally Billed (AGB). A summary of the current AGB percentage and the calculation methodology is available upon request from a Hospital Business Office at 541-426-5304.

Patients without Required Documentation: If a patient is unable to provide standard documentation for verifying income such as when the patient does not file income taxes or does not have bank accounts the Hospital will make reasonable efforts to verify the information provided. This may include considering proof of public assistance or verification from a caregiver, friend, or other reliable source. In such cases, the application must be signed by the patient attesting to the accuracy of the information provided.

If a patient is unwilling to provide the required information, financial assistance will not be granted. Deceased patients may be deemed to have no income for purposes of meeting eligibility requirements if there are no assets to satisfy the account.

Review of Applications: Completed applications for Financial Assistance will be reviewed, and patients will be notified in writing of the determination within 10 business days of receipt. Initial approval will be valid for nine months, after which patients will be asked to validate their financial and household information; if a subsequent approval is granted, it will be valid for an additional nine months.

Appeals of Financial Assistance Determinations (Effective Jan 1, 2025)

If a Financial Assistance Application is denied, incomplete, or approved for less than 100% adjustment, the Hospital will, within 10 business days, send the patient a notice explaining the reason and how to correct or appeal. Notices are sent separately from billing statements by mail, email, in person, or portal, and include contact information and the option to request review by the CFO or designee.

Patients may submit corrections or appeals by email/portal, mail, or in person. The deadline is the greater of the remaining 240-day application period or 45 days from our notice. Upon receipt of an appeal, all collections will be paused and any agency notified to do the same. If more information is requested during the appeal, the patient will have at least 45 additional days to respond.

A patient may authorize a representative to act on their behalf. Written appeal decisions will be issued within 30 days of the final meeting or receipt of all requested information and will state the date collections may resume, if applicable. Collections will not resume until after this notice. If an application first found incomplete is later denied for eligibility, the patient may appeal that denial.