July 1, 2024

TITLE
Financial Assistance Program

PURPOSE
To ensure that Sky Lakes provides financial assistance to its patients in a fair, consistent, and objective manner.

POLICY
Sky Lakes provides emergency care services pursuant to the Emergency Medical Treatment and Active Labor Act (EMTALA) regardless of a patient's insurance or financial status. Discounts for emergency services are determined after EMTALA obligations are met. Sky Lakes will give services free of charge for traditional, non-elective, and medically necessary services to patients who meet the financial requirements set by the facility and in accordance with applicable law. The Federal Poverty Income Guidelines published each year, will be used as the primary basis for assistance determinations.

Sky Lakes does not discriminate on the basis of race, ethnicity, color, religion, gender, sex, age, handicap, or national origin.

Financial assistance applies only to accounts billed by Sky Lakes. Other independent physicians (e.g., providers on medical staff who are not employed by Sky Lakes), including surgeons, pathologists and other specialists may bill separately. Hospital financial assistance would not be applied to those bills. Additionally, financial assistance cannot be applied to any ambulance, air flight or other transportation services.

Other **Excluded Hospital or Specialty Services** may include:
A. Services considered non-covered or not medically necessary by the State of Oregon Medicaid program or a patient's private insurance.
B. Non-emergent services provided to a patient who chooses to come to Sky Lakes out of their insurance plan network.
   Patients who have insurance but opt not to use it.
C. Elective procedures;
D. Take home prescriptions or supplies issued by the pharmacy; or
E. Durable medical equipment.

Prospective financial assistance recipients are welcome to receive a free Change Healthcare screening at any time prior to or during the application process. This is not a requirement to receive Sky Lakes financial assistance.

Presceening to Determine Presumptive Eligibility

Sky Lakes will perform a prescreening on eligible patients to determine presumptive eligibility for financial assistance.
The prescreening process and presumptive eligibility determination is not considered an application for financial assistance and does not disqualify a patient from seeking further financial assistance.

The prescreening process for presumptive eligibility is intended for patients:
A. With no insurance;
B. Experiencing houselessness;
C. Enrolled in a state medical assistance program; or
D. With a balance of at least $500 owed to the hospital after all adjustments from insurance or third-party payers, if applicable, have been made.

Sky Lakes may additionally prescreen patients who do not meet any of the criteria above at the hospital's sole discretion or as otherwise established in the hospital financial assistance policy.

Sky Lakes does not require patients to present documentation or verification related to any eligibility criteria as a part of the prescreening process or as a requirement for adjustment to the patient's costs.

Sky Lakes may use existing patient data as a basis for prescreening, including but not limited to:

A. Existing patient records;
B. Information routinely collected during patient registration or admission;
C. Information voluntarily supplied by the patient;
D. Previous financial assistance adjustments; and
E. Known existing eligibility for assistance programs, including, but not limited to: Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC), free lunch or breakfast programs, low-income home energy assistance programs, or any other program which are means tested and would reasonably establish a likely patient household income.

Sky Lakes may additionally use a third-party software tool known as Experian to assist in making an eligibility determination. This determination is based solely on household size and estimated income, and not on household assets, propensity to pay, or an ability to pay assessment. This inquiry will not cause a negative credit impact to the patient.

If the initial prescreening method fails to return information about the patient, the hospital will make a good faith effort to determine the patient's presumptive eligibility status based on other

information available to the hospital**,** including previous dates of Medicaid eligibility, previous hospital assistance awards, employment status, enrollment in government assistance programs and any additional information found readily in the patient's chart that would reasonably indicate qualification.

Upon determining a patient's presumptive eligibility for financial assistance, the hospital will notify the patient promptly by means of written notification delivered to the patient through the postal system or electronically to the patient's MyChart portal. The notification will include:

A. The outcome of the presumptive eligibility assessment.
B. The specific level and type of financial assistance granted.
C. Detailed instructions on how the patient can proceed if they wish to contest the determination or provide additional information for reassessment.

All presumptive eligibility determinations and the basis for these decisions will be thoroughly documented. This documentation will be maintained in the patient's financial records to ensure transparency and accountability in the assessment process.

If the prescreening process determines that the patient is not presumptively eligible, or their eligibility cannot be determined, or the patient cost adjustment was less than 100% of the patient cost amount, the patient has the following rights;

A. The patient may still apply for financial assistance, or additional financial assistance, through the standard hospital financial assistance application;
B. The patient may request and receive a physical application online or in person.
C. The patient may request assistance in completing the financial assistance application; and
D. The patient is eligible to apply for financial assistance for at least 240 days following the first billing statement for the services provided or at least 12 months after making a payment for the services provided, or for any additional time period beyond these minimums as specified in the hospital's financial assistance policies.

Financial Assistance

In addition to the prescreening provided to some patients, as stated above, patients are encouraged to apply for financial assistance.

Patients are eligible to apply for financial assistance for at least 240 days following the receipt of the first billing statement for the services provided, or at least 12 months after the patient pays for the services provided. Or a patient may apply for financial assistance for any account still in good standing, so long as an equal or larger amount of assistance was not already applied to the account.

If you require assistance in completing an application for financial assistance, Sky Lakes has representatives available to assist any patient or patient's representative in completing the application for assistance during the posted business hours of the Financial Counseling Department.

Applicants for financial assistance can complete a financial assistance packet (FAP), available at all Sky Lakes' registration areas, in the Financial Counseling Department, and on the hospital's website.

A. Patients completing a financial assistance application may be asked to provide the following:
   1. Three months of income verification. If a patient states that they or their spouse are unemployed or that they did not file taxes for the previous year, a wage record or other documentation may be required.
   2. Federal income tax records for the most recent filing year..
   3. Additional supporting documentation may be requested to make a final determination regarding household size and income.

Household income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

   A. Income includes earnings, unemployment compensation, worker's compensation, social security, supplemental security income, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, alimony, and child support.
   B. Benefits such as health insurance, food stamps, educational assistance and housing subsidies are excluded.
   C. Capital gains or losses are also excluded.

These are generally accepted guidelines. Please note that if a patient's financial circumstances, such as other medical bills, future earning capacity, or a major catastrophic event greatly affect a patient's ability to make future payments, there may be additional consideration for financial assistance.

B. Family size will be determined by the information supplied on the most recent federal income tax return of number of dependents claimed. If a patient's family size has increased since the last tax return was filed, the hospital may require additional documents (i.e. court decrees, proof of birth, etc.) to validate the change.
C. For accounts related to Motor Vehicle Accidents and On the Job Injuries, no charity care discount will be offered until a denial from the insurance is received. If later it is determined that litigation is in process or a settlement may be made, then the offer of charity may be withdrawn until a letter from the patient's attorney is received stating there is no settlement.
D. For each application the patient shall receive a letter of approval, denial or a letter explaining the additional information needed to process the application within 10 days.
E. Each application will be considered effective for 12 calendar months starting from the date of approval, but assistance can also be applied retroactively to any account in good standing, if assistance or a self-pay discount has not already been applied, or if the amount of assistance is now greater than an amount previously applied (only the difference between the two will be considered).
F. Self-pay payments made during the application process or after financial assistance is approved will be returned to the patient.

G. Any patient who has qualified for financial assistance will not be held financially liable for an annual patient balance in excess of 20% of the patient's total family income. Additionally, any individual deemed eligible for financial assistance under the financial assistance program will not be charged more than the amounts generally billed to individuals who have insurance for emergency or other medically necessary care.
H. To calculate the Amounts Generally Billed (AGB) Sky Lakes is using the "look-back method." This method bases AGB on fully processed inpatient, outpatient and clinic claims with a primary payor of Medicare fee-for-service, Military or a commercial payor (including Medicare Advantage plans) for each fiscal year. The sum of total payments made by those payers is then divided by the sum of total hospital charges for those claims to identify the "AGB percentage." Sky Lakes has set the minimum percentage write-off for FAP eligible individuals at 70% to assure that we continue to meet or exceed the AGB percentage discounts provided to other insured individuals seeking emergent or other medically necessary care. This minimum AGB percentage is reviewed each fiscal year to assure continued compliance.

Appeals Process

A. A patient may only appeal determinations based on applications for financial assistance.
B. If Sky Lakes Medical Center denies an application for financial assistance, finds the application to be incomplete or missing documentation, or provides a patient cost adjustment for less than 100% of the patient costs, the medical center shall, within ten (10) business days, notify the patient of their ability to take corrective action or appeal the determination.
C. The notification will be written in plain language in either the preferred language of the patient or otherwise in alignment with the translation standards specified in ORS 442.614.
D. The notification will be delivered by mail, email, in person, or through an online portal, if the patient is a registered user of the medical center's portal. The notification will be delivered separately and in addition to any financial assistance statements included on billing statements.
E. The notification will clearly specify whether the application was incomplete or if the patient was denied due to not meeting eligibility criteria.
F. If the application is found to be incomplete, missing documentation, or containing errors, the notification will designate the application as incomplete and requiring further action by the patient. The notice will further clearly describe the deficiencies and the actions the patient can take to complete the application by correcting the deficiencies.
G. If the application was denied based on a failure to meet eligibility criteria, the notification will specify the relevant eligibility criteria and provide contact information so that the patient can request further information about the relevant eligibility criteria and the information that was used by the medical center to reach its determination.
H. The notification will include a clear description of how the patient may submit corrections or additional documentation and how the patient may request an appeal. At a minimum, a patient will be able to submit corrections or additional documentations and request an appeal electronically, by either email or through a secure online portal, by mail, and by in-person delivery.
I. The notification will inform the patient that if the patient chooses to appeal, the patient may request review by the medical center's Chief Financial Officer or to any person designated by the CFO to have decision-making authority over the appeal.

J. The notification will inform the patient that the patient may also submit an appeal through a written statement or other supporting documentation.
K. The notification will provide contact information to an appropriate hospital representative who may answer questions about the appeals process or the patient's financial assistance application.
L. Sky Lakes Medical Center will allow a patient the remaining duration of the 240-day application period after the date of the first post-discharge billing statement for the care provided, as specified in 26 CFR 1.501(r)-1(b)(3), or 45-days from the date the patient was notified of the financial assistance determination to correct deficiencies in the application or request an appeal, whichever is greater. Sky Lakes Medical Center may conduct standard billing practices during the application period if there is not a pending appeal. However, this does not remove the medical center's obligation to reimburse a patient if found to be eligible for financial assistance, in accordance with ORS 442.615.
M. During the pendency of an appeal Sky Lakes Medical Center will:
    1. Suspend all collection activities if the medical center has initiated collection activities; and
    2. If the medical center has authorized a collection agency to collect debts on behalf of the medical center, the medical center will notify the collection agency to suspend collection activities; and
    3. Provide the patient with a written statement, delivered in accordance with OAR 409-023-0125(4)(b), and any request by the patient to use a specific, permitted, different delivery method, that contains:
        A. Confirmation of receipt of the patient's appeal request;
        B. Notice that:
            1. The medical center has suspended all collection activities that it has initiated; and
            2. If the medical center has sold debt to a collection agency or authorized a collection agency to collect debts on behalf of the medical center, that the medical center has notified the collection agency to suspend collection activities.
            3. Information on any actions the patient may take if a patient has requested a review by the medical center's Chief Financial Officer or a designee.
N. If it is determined by the medical center officer with the authority to determine the appeal that the patient will provide additional information, the patient will be allowed an additional 45 days, minimum, to provide the requested information. This additional time period runs from the date the medical center officer with the authority to determine the appeal informs the patient that they will need to supply additional information.
O. Sky Lakes Medical Center may allow for multiple meetings with the patient, or their designee, to make a decision about the appeal.
P. Sky Lakes Medical Center will allow for a third party acting with consent and on behalf of the patient to take action on a patient's application and/or represent the patient on appeal. Sky Lakes Medical Center may require documentation of consent to representation from the patient.
Q. Sky Lakes Medical Center will issue a written determination on the appeal within 30 days of either the date of the final appeals meeting or the date of receipt of corrections related to

application deficiencies, whichever is later. The medical center will communicate its determination in accordance with plain language and preferred language requirements established in OAR 409-023-0125(4)(a) and it will be delivered in accordance with OAR 409-023-0125(4)(b), and any request by the patient to use a specific, permitted, delivery method.

R. If the final determination results in a denial of financial assistance, the medical center will also notify the patient of the date on which suspended collection activities, if any, will resume.
S. Sky Lakes Medical Center may not resume suspended collection activities until a patient is notified of the final determination.
T. A patient who has taken corrective action on an application that was determined to have deficiencies may request an appeal if the application is subsequently denied based on a failure to meet the medical center's eligibility criteria.