SUMMIT PACIFIC MEDICAL CENTER 600 E Main Street Elma WA 98541	Title: Community/Charity Care Policy Department: Finance Pages: 3
Effective Date: 12/01/2014 Revised: 11/27/2016	Cross Reference Department: Company Wide
Approval: Board Signature CEO Signature CFO Signature Author name/title: Shauna DePrato, Finance Director	Date document scanned into system:

Summit Pacific Medical Center (SPMC) has adopted the name "Community Care" to replace the traditional "Charity Care".

SPMC is committed to the provisions of health care services to all persons in need of medical attention regardless of ability to pay. In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provisions of Community Care are consistent with the requirements the relevant laws and regulations of Washington Administrative Code, Chapter 246-453, as established. This criterion will assist the District in making consistent and objective decisions regarding the eligibility for Community Care while ensuring the maintenance of a sound financial base. Actions by staff are not limited by this policy. Rights and responsibilities provided by law and regulation will prevail.

Eligibility Criteria:
Community care is generally secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare, Medicaid or other medical assistance programs, other state, federal or military programs, third party situations (e.g. auto accidents or personal injury), or any other situations in which another person, entity, trusts, and estates, sovereign nation may have a legal responsibility to pay for the costs of medical services.

In situations where payment sources are not available, patients' balances will be considered for Community Care under this policy based on the following criteria:

- The full amount of the District charges will be determined to be to be Community Care for any patient whose gross family income is up to 200% of the current federal poverty guidelines.
- The related year's sliding fee schedule will be used to determine which will be written off for the patients with incomes between 200% and 300% of the current federal poverty level. The sliding fee schedule shall take into account the potential necessity for allowing the responsible party to satisfy the maximum amount of charges for which the responsible party will be expected to provide payment based on the District's approved Patient Account Collection Policy.

Catastrophic Community Care:
The District may also write off, as Community Care, amounts for patients with family income in excess of 300% of the federal poverty standards or at a higher percentage of those above 200% of the poverty guidelines, when circumstances indicate severe financial hardship or personal loss. This will be done only upon recommendation by the business/billing office and/or finance department with adequate justification, and only upon approval by the Chief Financial Officer and/or his or her delegate.

Process for Eligibility Determination:
The District will use the application process for determining initial interest in, and qualification for, Community Care. Community Care applications will be furnished to patient when Community Care is requested, when need is indicated, or when financial screening indicates potential need. Applications, whether initiated by the patient, or the District, should be accompanied by documentation to verify income amounts indicated on the application form.

One or more of the following types of documentation may be accepted for purposes of verifying income when applications are submitted for processing:

- W-2 withholding statements for all employment during the relevant time period.
- Copies of current pay stubs from all employment.
- An income tax return from the most recently filed calendar or other IRS documentation denoting income.
- Notice of in-state or out-of-state Medicaid eligibility, forms approving or denying eligibility of Medicaid and/or state funded medical assistance or indications based on the Medicaid Eligibility Work Sheet indication the patient would not be eligible.
- Forms approving or denying unemployment compensation.
- Written statements from employers or welfare agencies.

The income amounts will be annualized from the date of service based upon documentation provided. The annualization process will be calculated by the District and will take into consideration seasonal employment and temporary increases and/or decrease of income. Income deductions and other medical debt may also be taken into consideration.

In the event that the responsible party is unable to provide any income documentation to determine sponsorship status, the District may rely upon information provided orally or in the form of a written statement. A good faith effort to obtain the patient's signature, confirming the documented financial conditions of the indigent person, shall be made. In circumstances where a patient is unable or not willing to sign an attestation document, such can be noted on the application by the District employee.

All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.

A higher determination may be granted for approval of sponsorship based on additional information obtained from the patient and/or caregivers that are familiar with the patient's situation.

Time Frame for Determination:
The facility/hospital will provide final determination within fourteen (14) days of receiving their information. The form will state the amount the patient is responsible for and the amount to be forgiven. The determination will be valid for six (6) months following approval.

Pending final eligibility determination, the District will not initiate collection efforts or request for deposits, provided that the responsible party is cooperative with the hospital's efforts to reach a determination of eligibility.

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 charity care criteria at the time that services were provided, any payments in excess of the amount determined to be appropriate in accordance with WAC 246-453-040 shall be refunded to the patient within thirty days of achieving the charity care designation.

Denials will be written and include instructions for appeal or reconsideration as follows:
The applicant may appeal the determination of eligibility for Community Care by providing additional information related to their financial wellbeing to the business office within thirty (30) calendar days of receipt of notification. However, on the fifteenth (15) calendar day, if no appeal has been filed, the District may initiate collection activities. The business office and the administration will review all appeals and the results of such determination will be communicated in writing to the related applicant. If the District has initiated collection activities and discovers an appeal has been filed, we will cease collection efforts until the appeal is finalized.

Public Notification:
The District's Community Care policy will be publically available on our external website, and notice that Community Care is available will be posted on signs in the facilities, and on written materials provided to patients.