

**MASON GENERAL HOSPITAL
UNCOMPENSATED CARE**

Mason General Hospital is committed to the provision of emergency 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 provision of charity care, consistent with the requirements of WAC 246-453, are established. These criteria will assist staff in making consistent and objective decisions regarding eligibility for charity care while ensuring the maintenance of a sound financial basis.

ELIGIBILITY CRITERIA

A. The full amount of hospital charges will be determined to be charity care for a patient whose gross family income is at or below 100% of the current federal poverty guidelines (consistent with WAC 261-14-027).

B. The following sliding fee schedule shall be used to determine the amount which shall be written off for patients with incomes between 101% and 400% of the current federal poverty level.

Size of Family	Poverty Guideline	Greater Than	Less Than	Greater Than	Less Than	Greater Than	Less Than
1	11,170	11,170	15,638	15,638	20,106	20,106	24,574
2	15,130	15,130	20,981	20,981	26,977	26,977	32,968
3	19,090	19,090	26,324	26,324	33,848	33,848	41,361
4	23,050	23,050	31,668	31,668	40,720	40,720	49,755
5	27,010	27,010	37,011	37,011	47,591	47,591	52,243
6	30,970	30,970	42,354	42,354	49,970	49,970	54,855
7	34,930	34,930	44,472	44,472	52,469	52,469	57,598
8	38,890	38,890	46,695	46,695	55,092	55,092	60,478
Discount	100%	90%		80%		70%	

Size of Family	Greater Than	Less Than	Greater Than	Less Than	Greater Than	Less Than	Greater Than	Less Than
1	24,574	29,042	29,042	33,510	33,510	37,978	37,978	44,680
2	32,968	38,962	38,962	44,956	44,956	50,950	50,950	59,941
3	41,361	48,882	48,882	56,402	56,402	63,922	63,922	75,203
4	49,755	58,801	58,801	67,848	67,848	76,894	76,894	90,464
5	52,243	61,742	61,742	71,240	71,240	80,739	80,739	94,987
6	54,855	64,829	64,829	74,802	74,802	84,776	84,776	99,736
7	57,598	68,070	68,070	78,542	78,542	89,015	89,015	104,723
8	60,478	71,474	71,474	82,469	82,469	93,465	93,465	109,959
Discount	60%		50%		40%		30%	

***Add \$3960 for each additional family member over 8**

CATASTROPHIC CHARITY CARE

The hospital may also write off as charity care amounts for patients with family income in excess of 400% of the federal poverty standards or at a higher percentage for those above 100% of the poverty guidelines, when circumstances indicate severe financial hardship or personal loss. This will be done only upon recommendation by the patient accounts representative or business office manager with adequate justification, and only upon approval by Administration and the Hospital Board of Commissioners.

PROCESS FOR ELIGIBILITY DETERMINATION

Initial Determination:

The hospital will make an initial determination of eligibility based on written application for charity care. Pending final eligibility determination, the hospital will not initiate collection efforts or requests deposits, provided that the responsible party is cooperative with the hospital's efforts to reach a determination of sponsorship status, including return of applications and adequate documentation.

The hospital shall use an application process for determining initial interest in and qualification for charity care. Should patients not choose to apply for charity care, they shall not be considered for charity care unless other circumstances become known to the hospital.

Final Determinations:

Charity care forms, instructions, and written applications shall be furnished to patients when charity care is requested, when need is indicated, or when financial screening indicates potential need. Applications, whether initiated by the patient or the hospital 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 acceptable for purpose of verifying income:

1. W-2 withholding statements for all employment during the relevant time period;
2. Pay stubs from all employment during the relevant time period;
3. An income tax return from the most recently filed calendar year;
4. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance (denial for Medicaid purely on the basis of failure to apply timely will never be sufficient documentation by itself), if applicable;
5. Forms approving or denying unemployment compensation; or
6. Written statements from employers or welfare agencies. Patients will be asked to provide verification of ineligibility for Medicaid or Medical Assistance. During the initial request period, the hospital may pursue other sources of funding, including Medicaid.

Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. This process will be determined by the hospital and will take into consideration seasonal employment and temporary increases and/or decreases of income.

Time Frame for Final Determination and Appeals:

The hospital shall provide final determination within fourteen days of receipt of all application and documentation material.

Denials:

Denials will be written and include instructions for appeal or reconsideration as follows. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income and family size to the Patient Accounts Representative within fourteen days of receipt of notification. All appeals will be reviewed by the Patient Accounts Representative, and the Business Office Manager.

If this determination affirms the previous denial of charity care, written notification will be sent to the patient/guarantor and the Department of Health in accordance with state law.

DOCUMENTATION AND RECORDS

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

B. Documents pertaining to charity care shall be retained for five (5) years.

NOTIFICATION

Public Notification: the hospital's charity care policy shall be publicly available through the posting of a sign and the distribution of written materials indicating the policy to patients at the time that the hospital requests information pertaining to third party coverage. The hospital finds that the following non-English translations of this document shall be made available because more than 10% of the population in the service area speaks this language: Spanish .

MGH: 05/91 MGH: 02/94 MGH: 04/97 MGH: 03/00 MGH: 02/03 MGH: 04/09
MGH: 04/92 MGH: 03/95 MGH: 02/98 MGH: 02/01 MGH: 02/04 MGH: 02/11
MGH: 04/93 MGH: 05/96 MGH: 04/99 MGH: 03/02 MGH: 01/05 MGH:01/12
MGH: 01/06 MGH: 05/06 MGH: 03/07 MGH: 03/08 MGH: 08/08

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APPLICATION FOR DETERMINATION FOR ELIGIBILITY FOR UNCOMPENSATED CARE

Please complete all items

Date of Request: _____

I hereby request that Mason General Hospital make a written determination of my eligibility for Uncompensated (Charity) Care services at Mason General Hospital. I understand that the information which I submit concerning my annual income and family size is subject to verification. I also understand that if the information I submit is determined to be false, such a determination will result in a denial of uncompensated services and that I will be liable for charges for services provided.

1. NAME _____ PHONE# _____

First Middle Last

2. ADDRESS _____
PO Number/Street City State Zip Code

3. OCCUPATION _____ EMPLOYER _____
If unemployed, last date worked _____

4. EMPLOYER OF OTHER FAMILY MEMBERS _____

5. INCOME* TOTAL FAMILY INCOME RECEIVED FOR THE LAST 3 MONTHS _____

6. INCOME* TOTAL FAMILY INCOME RECEIVED FOR THE LAST 12 MONTHS _____

*Income is the total cash receipts before taxes from all sources including the patient's income and income of other family members living in the same household to include such things as wages, farm or self employed income, public assistance, social security, unemployment compensation, alimony, child support, pensions, and other.

VERIFICATION OF INCOME

Verification of income is required for determination of eligibility of Uncompensated (Charity) Care. Please indicate which of the following you are attaching to this application.

Pay check stubs _____ Income Tax Form _____ Other _____

7. IF NO INCOME, an explanation of the circumstances for no income must be made below:

8. NUMBER OF PERSONS IN FAMILY _____

9. LIST FAMILY MEMBERS

	NAME	RELATIONSHIP
PATIENT	_____	_____
OTHERS	_____	_____
	_____	_____
	_____	_____
	_____	_____

10. PATIENT CARE SERVICES INFORMATION (What services do you want considered?)

Prior Medical Service? Date(s) of service _____

List Patients who received service(s):

Medical Service not yet rendered? Type of service(s) _____

Date(s) of service _____

List Patients who received service(s):

I/WE HEREBY AUTHORIZE Mason General Hospital to verify the above information including employment history and to check the information on file at the credit bureau(s) or any other source named in the application. I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Washington Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges, and I will take any reasonable action necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can judge my eligibility for Uncompensated Care Services based on the established criteria on file in the hospital. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial state and take whatever action becomes appropriate.

Applicant's Signature _____ Date of Request _____