SUBJECT:	Financial Assistance Policy	POLICY NO.: 960-FM-210
DEPARTMENT:	Finance	PAGE: 1 of 6
APPROVED BY:	Harney County Health District Board of Directors	DATE EFFECTIVE: 12/1/2014
DATE APPROVED:	08/06/2025	REVIEWED/REVISED: 08/06/2025

1. **Policy and Purpose**:

1.1. Harney County Health District (the "District") is committed to providing financial assistance to improve access to care for patients who are unable to pay for healthcare services.

1.2. The District's practice is to provide emergency or other medically necessary care,[1] without discrimination, to all patients regardless of ability to pay.

1.3. A patient is eligible for financial assistance under this Financial Assistance Policy (Policy) based upon meeting certain income eligibility criteria that are derived from the Federal Poverty Guidelines (FPG) posted annually in the Federal Register by the Department of Health and Human Services. (http://aspe.hhs.gov/poverty-guidelines).

Specifically, discounts will be based on income and household/family size only. The District uses the Census Bureau definitions of each:

1.3.1. Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

1.3.2. Income includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.

1.4. A sliding scale will be used to determine discounts when family adjusted gross income is between 200 and 400% of FPG. Financial assistance will be granted based on the following eligibility criteria and discount percentages, which such percentages will be applied as described immediately below the chart:

Family Adjusted Gross Income as a Percent	% Discount of Total Patient Responsibility on Account
0% - 200%	100%
201% - 300%	75%
301% - 350%	50%
351% - 400%	25%

[1] All references to "care" in the remainder of this Policy (as well as all Exhibits) shall be interpreted to be limited to emergency and other medically necessary care.

1.5. All patients seeking healthcare services at the District are assured they will be served regardless of ability to pay. No one will be denied access to services due to an inability to pay. There is a discounted/sliding fee scale schedule available based on family size and income. Requests for discounted services may be made by a patient, any individual who has accepted or is required to accept responsibility for the patient's bill ("guarantor"), family members of the patient, social services staff or others who are aware of existing financial hardship.

2. Pre-Screening For Presumptive Eligibility

2.1. In accordance with Oregon HB 3320, the District will pre-screen for presumptive financial assistance eligibility before the first bill for services is sent to any patient who is uninsured, is enrolled in a state medical assistance program, or will owe the hospital $500 or more after all adjustments from insurance or third-party payers. The prescreening is separate from the financial assistance application process described below and does not disqualify a patient from seeking further financial assistance. The prescreening process use the financial assistance eligibility standards noted above and in accordance with the minimum standards specified by Oregon law.

2.2. The District's prescreening process will consist of reviewing existing patient records and information routinely collected during patient registration to assess the patient's presumptive eligibility. Where that information does not reveal the patient's presumptive eligibility or provides that the patient is eligible for less than full financial assistance, the District will contact the patient by telephone to notify the patient that the patient may voluntarily provide information that the District will use in assessing the patient's presumptive eligibility. For a patient who has applied for and was awarded financial assistance in the twelve months preceding the prescreening, the District will provide presumptive financial assistance in the amount of the previous financial assistance award.

2.3. The District will notify patients in writing that they have been prescreened and the results of the prescreening, of which there are four possible outcomes: presumptively eligible for full financial assistance, presumptively eligible for partial financial assistance, presumptively denied financial assistance, or unable to determine presumptive eligibility. Where the patient is approved for partial financial assistance, the District will inform the patient of the discount amount approved. If the patient disagrees with the approved discount amount, was denied presumptive financial assistance, or was not provided presumptive financial assistance because the District was unable to determine the patient's presumptive eligibility, the patient may contact Patient Financial Services and request a Financial Assistance Application form ("FAP form"). See below for information regarding the financial assistance application process.

2.4. Each approved prescreening Financial Assistance case will be valid for 9 months from the date

that the FPL was obtained. A patient may opt out of receiving a presumptive financial assistance award. To opt out of receiving the presumptive award, the patient or patient's guarantor must sign the Opt Out of Oregon HB 3320 Discount form. The patient or patient's guarantor can obtain this form from the Patient Financial Counselors.

2.5. Out-of-state residents will be prescreened for presumptive eligibility, however, if they qualify for a presumptive discount it will not be applied. The District will send out-of-state residents a letter stating that they were prescreened but were denied for the presumptive discount. Out-of-state residents may still apply for Financial Assistance by filling out an FAP application form and providing the required documentation.

3. Financial Assistance Application Process

3.1. To be considered for financial assistance, a patient and/or a patient's guarantor[2] must submit a complete FAP application form to the District's Patient Financial Services Department with supporting documentation as outlined on the form. The FAP application form may be obtained by mail by calling 541-573-8638; downloaded from the District's web site at http://www.harneydh.com/services/patient-financial-services/; or picked up at the District's Patient Financial Services office, emergency room, or admissions areas. By signing the FAP application form, persons authorize the District access in confirming income and household size as disclosed on the application form.

3.2. If a patient is determined to be eligible for financial assistance, such financial assistance will be secondary to all other financial resources available to the patient including insurance, government programs, and third-party liability. Financial assistance amounts are based on the patient's total household/family size and family income and the patient's cooperation in applying for Medicaid or other third party payment options that may be available to the patient.

3.3. Patients may apply for financial assistance within 240 days after the date of the first post-discharge billing statement for the care provided or up to 12 months after the patient pays for the services. If a patient applies for financial assistance after having paid for the services for which the patient qualified, the District will refund the amount of financial assistance for which the patient qualified. If the District previously determined, incorrectly, that the patient did not qualify for financial assistance for the services based on information provided by the patient at the time of the incorrect determination, the District will also pay the patient interest on the amount of financial assistance at the rate set by the Federal Reserve and any other associated reasonable costs incurred by the patient in securing financial assistance. If the District sold the

[2] All references to "patient" in the remainder of this Policy (as well as all Exhibits) shall be interpreted to include guarantors, where applicable.

patient's debt to a collection agency or authorized collection agency to collect debts on behalf of the District, the District will notify the collection agency that the debt is invalid.

3.4. Upon receipt of the completed FAP application form, the District will notify patient of financial assistance determination within 21 calendar days. When a patient is determined to be eligible for financial assistance with respect to care for which a patient timely submitted a FAP form, the District will factor into the patient's remaining balance any sum already paid by the patient, if any. See Exhibit A for discounts other than financial assistance.

3.5. Notwithstanding paragraph 3.4 above, no patient determined to be eligible for financial assistance ("FAP-eligible patient") for care will be personally responsible for having paid or paying more for the care than the amount the District generally bills to individuals who have insurance ("AGB").[3] A patient's eligibility determination will be applied prospectively for the 12 months following the date of the patient's FAP application form. If the patient believes his or her financial situation has changed such that he or she may be eligible for more financial assistance under this Policy, a new FAP application form may be submitted.

3.6. Except for care provided in the District by a provider described in Exhibit B, the discounts described in this Policy shall apply to all emergency and other medically necessary care provided in the District. However, the discounts will not be applied to services that are purchased from and provided outside of the District, including reference laboratory testing, drugs, and imaging study interpretation by a consulting radiologist.

3.7. Patient net amount due after financial assistance discount is to be paid within 30 days from notice of financial assistance determination.

3.8. The actions that the District may take in the event of nonpayment are outlined in its Billing and Collections policy, which may be obtained as described under "Notification" below.

3.9. The District may grant extended payment arrangements for patient responsibility after financial

[3] 76.5% reflects the amounts that the District generally bills to individuals who have insurance ("AGB"), which is determined by dividing the sum of all amounts of all of the District's claims for care that were allowed by Medicare in its fiscal year ending June 30, 2024, by the sum of the associated gross charges for those claims (i.e., using the "look-back" method described in Treas. Reg. §1.501(r)-5(b)(3)).

In addition to the discounts and AGB limitation described above, the total net amount that a FAP-eligible patient will be personally responsible for paying to the District (that is, after all third party payments have been applied) may not exceed more than 20% of the patient's annual family income in a calendar year. It is the responsibility of the patient to notify the District when net due exceeds 20% of adjusted gross income. This same cap at 20% of annual family income also applies to patients that are not FAP-eligible. See Exhibit A.

assistance is applied to include monthly payments of at least 5% of the original patient responsibility, but no less than $25 per month and will be documented in the patient account. All extended payment arrangements will comply with Federal and State guidelines and disclosures.

4. Appeals Process

4.1. Patients who have submitted a FAP application form and disagree with the decision or discount amount, or a patient who had their FAP application denied due to incomplete or missing documentation, may submit an appeal. All patients that have received a partial discount amount or a denial will be sent a letter explaining the appeals process. In order to appeal, the patient, or a third party acting with consent and on behalf of the patient, must submit a written letter to the Chief Financial Officer "CFO" of the District.[4] The patient has the greater of the remaining duration of the 240-day FAP application period or 45 calendar days from the date the patient was notified of the financial assistance determination to request the appeal or correct deficiencies in the FAP application (if FAP was denied for that reason). The appeal must explain why the patient believes the discount amount or denial of the financial assistance is inaccurate. The patient may also include any documentation that was not attached to the FAP application form in order to support the appeal. If the CFO determines that the patient must provide additional information, the patient will have 45 days from the date the CFO informs the patient that they must supply additional information to provide the requested information. The District will suspend all collection efforts until the CFO issues a decision on the appeal and notify the patient that such efforts have been suspended.

4.2. The CFO will review the appeal and supporting documentation along with the original FAP application form within 21 days of receiving the appeal and all requested documentation. The CFO will respond in writing informing the patient of their decision. If the patient's appeal affirms the District's FAP application decision, the District will include in its written notification the date on which suspended collection activities, if any, will resume.

4.3. The CFO's decision will be the final decision, and no further appeals will be accepted. Patients are allowed one appeal per application. A patient who has taken corrective action on a FAP application that was determined to have deficiencies may request an appeal if the application is subsequently denied based on a failure to meet the hospital's FAP eligibility criteria.

5. **Notification**:

5.1. This Policy, along with a plain language summary of its contents and the FAP application form, as

[4] A third party acting with consent and on behalf of the patient to take action on the patient's application and/or represent the patient on appeal must provide written documentation of consent from the patient.

well as Harney County Health District's Billing and Collection Policy, will be posted on the District web page at http://www.harneydh.com/services/patient-financial-services/. In addition, paper copies of these documents will be provided upon request by mail and in the hospital's emergency room and admissions areas, as well as in its Patient Financial Services office. Translations of all of these documents are available in Spanish. The District will also notify patients about its Policy by posting notifications on patient billing statements and in the hospital's emergency room and admissions areas, which such notices will inform patients of the availability of financial assistance. The District will also offer a paper copy of the plain language summary of this FAP to patients as part of its intake process. Finally, the District will publish an ad in a local newspaper at least twice a year that will inform its community about the availability of financial assistance.

References:
ORS 442.601-442.630