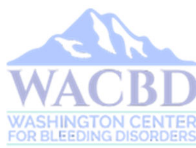

Patient Financial Assistance Program Policy	Department: Clinical, Billing/Contracts, Financial	
Origination Date: 05/01/2022	**Effective Date:** 05/04/2022	**Next Review Date:** 05/04/2025
Policy Contact: Joseángel Guerrero, Joseángel.guerrero@wacbd.org	**Version:** #1	
Written By: Mary Spisak Mary.spisak@wacbd.org, Christine Sellers Christine.sellers@wacbd.org		

PURPOSE: Some patients cared for at WACBD do not have the means/funds to fulfill their financial obligations to WACBD, particularly the underinsured, uninsured, homeless, or low-income. This policy will define who can qualify to receive support under this Patient Financial Assistance Program, how much assistance may be received, and how to apply for services under the program.

SCOPE: The scope of this policy applies to all WACBD patients

POLICY STATEMENT: WACBD is committed to improve access to coordinated and comprehensive systems of care for people and their families affected with hemophilia and related bleeding and clotting disorders. This includes: 1) providing services to those without adequate health insurance and 2) outreach to underserved and unserved people with hemophilia and other congenital bleeding disorders. Outreach efforts should include those with insurance restrictions; Medicaid eligibility; and low income. To protect the integrity of operations and fulfill this commitment, the following criteria for the provision of financial assistance, consistent with the requirements of the RCW 70.170 and Washington Administrative Code (WAC), Chapter 246-453[CS1], are established. These criteria will assist staff in making consistent objective decisions regarding eligibility for financial assistance while ensuring the maintenance of a sound financial base.

DEFINITIONS:

Term	Definition
FPL	Federal Poverty Level
Income	Sources of Income include, for example: Wages – Unemployment – Self-employment – Worker's compensation – Disability – SSI – Child/spousal support – Work study programs (students) – Pension – Retirement account distributions – Other

PROCEDURES:

Procedure 1- Eligibility Criteria	
General	Financial assistance and charity care are generally secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare, Medicaid or medical assistance programs, other state, federal, or military programs, third party liability situations (e.g., auto accidents or personal injuries), or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services. Patients will be granted financial assistance and charity care regardless of race, creed, color, national origin, sex, sexual orientation, immigration status, or the presence of

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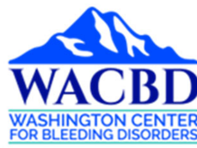

	any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a disabled person
Criteria	In those situations where appropriate primary payment sources are not available, patients shall be considered for financial assistance and charity care under this policy based on the following criteria: • The full amount of uncovered 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 level (FPL). • WACBD shall provide a sliding scale discount for patients with incomes between 101 % and 325 % of the current federal poverty level (FPL). At the upper end of the sliding scale, the discount will be at least 10%. [sliding scale table below] WACBD shall update the sliding scale at least annually to accommodate changes to the federal poverty rates.
Catastrophic Charity	WACBD may write off as charity care, amounts for patients with family income more than 325% of the federal poverty level when circumstances indicate severe financial hardship or personal loss. Any catastrophic charity consideration must be approved by WACBD's Financial Assistance Committee.
Collection	The responsible party's financial obligation which remains after the application of any sliding fee schedule shall be payable as negotiated between WACBD and the responsible party. The responsible party's account shall not be turned over to a collection agency unless payments are missed or there is some period of inactivity on the account, and there is no satisfactory contact with the patient.
Financial Disclosure	WACBD shall not require a disclosure of the existence and availability of family assets from financial assistance and charity care applicants whose documented income is less than 100% of the current federal poverty level but may require a disclosure of the existence and availability of family assets from financial assistance and charity care applicants whose income is at or above 101 % of the current federal poverty

Income as % of FPL	**% Discount**
326% and above	0%
325%	10%
300%	20%
275%	30%
250%	40%
225%	50%
200%	60%
175%	70%
150%	80%
125%	90%
100%	100%

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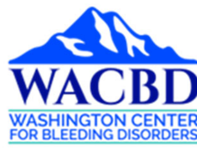

	level.

Procedure 2- Process for Eligibility Determination	
Initial Determination	1. WACBD shall use an application process for determining eligibility for financial assistance and charity care. Requests to provide financial assistance and charity care will be accepted from sources such as physicians, community or religious groups, social services, financial services personnel, and the patient, provided that any further use or disclosure of the information contained in the request shall be subject to the Health Insurance Portability and Accountability Act privacy regulations and 's privacy policies. All requests shall identify the party that is financially responsible for the patient ("responsible party"). 2. The initial determination of eligibility for financial assistance and charity care shall be completed as soon as possible following initiation of services to the patient. 3. Pending final eligibility determination, WACBD will not initiate collection efforts or request deposits, provided that the responsible party is cooperative with WACBD's efforts to reach a final determination of sponsorship status. 4. If WACBD becomes aware of factors which might qualify the patient for financial assistance or charity care under this policy, it shall advise the patient of this potential and make an initial determination that such account is to be treated as qualified to receive financial assistance or charity care pending a final determination.
Final Determination	1. Financial assistance and charity care forms, instructions, and written applications shall be furnished to the responsible party when financial assistance or charity care is requested, when need is indicated, or when financial screening indicates potential need. All applications, whether initiated by the patient or WACBD, should be accompanied by documentation to verify information indicated on the application form. Any one of the following documents shall be considered sufficient evidence upon which to base income levels for the purposes of charity care eligibility: a. A "W-2" withholding statement. b. Pay stubs from all employment during the relevant time period. c. Unemployment or Disability income payments during the relevant time period. d. An income tax return from the most recently filed calendar year. Other documents that may be requested to establish eligibility may include: a. Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance. b. Forms approving or denying unemployment compensation. c. Written statements from employers or DSHS employees. 2. During the initial request period, the patient and WACBD may pursue other sources of funding, including Medical Assistance and Medicare. The responsible party will be required to provide written verification of

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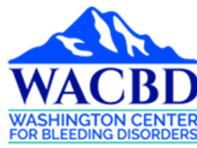

	ineligibility for all other sources of funding. 3. Usually, the relevant time period for which documentation will be requested will be three months prior to the date of application. However, if such documentation does not accurately reflect the applicant's current financial situation, documentation will only be requested for the period of time after the patient's financial situation changed. 4. If the responsible party is not able to provide any of the documentation described above, WACBD shall, at its discretion, rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person. (WAC 246-453-030(4)). 5. Then final determination to grant financial assistance will be made by the Financial Assistance Committee
Timeframe for Final Determination and Appeals	1. Each financial assistance and charity care applicant who has been initially determined eligible for charity care shall be provided with at least fourteen (14) calendar days, or such time as may reasonably be necessary, to secure and present documentation in support of his or her charity care application prior to receiving a final determination of sponsorship status. 2. WACBD shall notify the applicant of its final determination within fourteen (14) days of receipt of all application and documentation material. 3. The responsible party may appeal a denial of eligibility for charity care by providing additional verification of income or family size to the Financial Assistance Committee within thirty (30) days of receipt of notification. 4. The timing of reaching a final determination of charity care status shall have no bearing on the identification of charity care deductions from revenue as distinct from bad debts, in accordance with WAC 246-453-020(10).[CS2]
Patient Reimbursement	If the patient or responsible party has paid some or all the bill for medical/pharmacy services and is later found to have been eligible for financial assistance or charity care at the time services were provided, he/she shall be reimbursed for any amounts in excess of what is determined to be owed. The patient will be reimbursed within thirty (30) days of receiving the financial assistance or charity care designation.
Adequate Notice of Denial	1. When an application for financial assistance and charity care is denied, the responsible party shall receive a written notice of denial which includes: a. The reason or reasons for the denial. b. The date of the decision; and c. Instructions for appeal or reconsideration. 2. When the applicant does not provide requested information and there is not enough information available for WACBD to determine eligibility, the denial notice also includes: a. A description of the information that was requested and not provided, including the date the information was requested. b. A statement that eligibility for charity care cannot be established based on information available to WACBD; and

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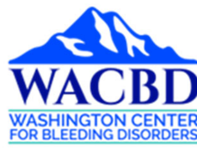

	3. That eligibility will be re-determined if, within thirty (30) days from the date of the original denial notice, the applicant provides all specified information previously requested but not provided. a. The Financial Assistance Committee will review all appeals and notification made in writing to the responsible party within thirty (30) days. If this review affirms the previous denial of financial assistance and charity care, the responsible party will be expected to accept this decision as final and make payment arrangements for any balance(s) due
Re-evaluation	If a patient has been found eligible for financial assistance or charity care and continues receiving services for an extended period of time without completing a new application, WACBD shall re-evaluate the patient's eligibility for financial assistance and charity care at least annually to confirm that the patient remains eligible. WACBD may require the responsible party to submit a new financial assistance and charity care application and documentation.

Procedure 2- Process for Eligibility Determination	
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.
Retention of Records	Documents pertaining to financial assistance and charity care shall be retained for five (5) years.

APPROVING COMMITTEE(S):
- Financial Assistance Committee
- Policy and Compliance Committee

REVISION HISTORY

	Final Approval by	Date	Brief description of change/revision
Revision			
Revision			

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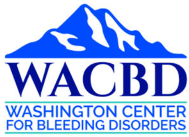


Patient Financial Assistance Program Application **Confidential**

Please fill out all information completely. If it does not apply, write “N/A.” Attach additional pages.

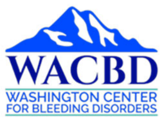
Screening Information	
Do you need an interpreter? ☐ Yes ☐ No	If yes, preferred language?
Has the patient applied for Medicaid? ☐ Yes ☐ No - *May be required to apply before being considered for financial assistance.*	
Does the patient receive state public services such as TANF, Basic Food or WIC? ☐ Yes ☐ No	Is the patient currently homeless? ☐ Yes ☐ No
Is the patient’s medical care need related to a car accident or work injury? ☐ Yes ☐ No	

Please Note
We cannot guarantee you will qualify for financial assistance. Once you send in your application, we check all the information and may ask for additional information. Within 14 calendar days after we receive your completed application and documents, we will notify you if you qualify for assistance.

Patient and Applicant Information		
Patient first name	Patient middle name	Patient last name
Person Responsible for Paying Bill	Relationship to patient	
Mailing Address ____ ____________________ City	State	Zip
Phone Number	Secondary phone number	Email address
Employment status of person responsible for paying bill ☐ Employed (date of hire: ______________) ☐ Part-time ☐Full-time ☐ Unemployed (how long unemployed: ______________________) ☐ Self-employed ☐ Student ☐ Disabled ☐ Retired ☐ Other (_____________________)		

Family Information
List family members in your household. “Family” is (a) Adult persons related by blood or marriage; (b) adult persons who are presently residing together or who have resided together in the past; and (c) persons who have a biological or legal parent-child relationship, including stepparents and stepchildren and grandparents and grandchildren. Family size _____________ *Attach additional pages if needed*

All adult family members’ income must be disclosed. Sources of Income include, for example: Wages – Unemployment – Self-employment – Worker’s compensation – Disability – SSI – Child/spousal support – Work study programs (students) – Pension – Retirement account distributions – Other (Please explain________________________________)



Patient Financial Assistance Program Application **Confidential**

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
1.					Yes / No
2.					Yes / No
3.					Yes / No
4.					Yes / No
5.					Yes / No

Income Information

Remember: You must include proof of income with your application.

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation you may submit a written statement describing your income. Please supply the following items for proof of income:

If you are employed:

- Copy of last year's tax return AND
- Copy of two most recent pay-stubs

If you are unemployed:

- Copy of last year's tax return AND
- Copy of last two months bank statements

Expense information

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

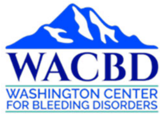
Rent/Mortgage $______________________________ Medical Expenses $_________________________

Insurance Premiums $__________________________________ Utilities $__________________________

Other Debt/Expenses $_________________________________ (child support, loans, medications, other)

Additional Information

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss. If you have recently qualified for other financial assistance or aid, including Medicaid, include a copy of the approval letter with your application. We may consider this when reviewing your application.



Patient Agreement	
I understand that Washington Center for Bleeding Disorders may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans. I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance and I may be responsible for and expected to pay for services provided.	
Signature of person applying	Date:
Signature of patient	Date:

WACBD FPL Sliding Scale Calculation

Updated 3/15/2022

Based on a single person. For each additional dependent there is another $394 monthly/$4720 annual reduction to the income calculation.

100% FPL Increments up to 500% Max

= 20% Discount Increments

	Adj Monthly Income	-	Annualized		
% of FPL	**From**	**To**	**From**	**To**	**Charity Adj**
501%	5,665.01	Above	67,980.01	Above	0%
500%	4,532.01	5,665.00	54,384.01	67,980.00	20%
400%	3,399.01	4,532.00	40,788.01	54,384.00	40%
300%	2,266.01	3,399.00	27,192.01	40,788.00	60%
200%	1,133.01	2,266.00	13,596.01	27,192.00	80%
100%	0.00	1,133.00	0.00	13,596.00	100%

Family size adjustment - adj for $394 monthly ($4,720 annually) for each additional person.

SOURCE = US Department of Health and Human Services

Poverty Guidelines - 48 Contiguous States & District of Columbia
https://aspe.hhs.gov/poverty-guidelines

Federal Register Notice dated 1/12/2022

Republished as HRSA Medical Income and Resource Standards

	Annual	Monthly
Dependants = 1 (self)	13,590	$ 1,133.00
Additional Dependants	4,720	$ 394.00

UPDATES:
In the purple box, update the Dependant and Additional Dependents
cells highlighed in yellow using the most recent FPL.
Monthly and Annualized income amounts will automatically update
in the sliding scale (blue) box.