

Jefferson Healthcare
Hospital, Clinics, Home Health and Hospice, Diagnostic and Rehabilitation Services
Port Townsend, WA 98368
360-385-2200 X 2267

CREDIT POLICY

Dear Patient:

It is our policy to provide quality medical care to any individual regardless of their financial status. The following credit policy was developed to provide financial assistance.

- **Prompt Pay Discount:** A 10% discount will be provided to self-pay patients for payment in full within 30 days of mailing your itemized bill.
- **Payment Arrangements:** Patients may make monthly payments on accounts paying the balance in full within three months. If this is not financially possible, formal arrangements must be made with the Financial Services Representative for hospital services.
- **Medicaid/DSHS:** Patients who have no insurance or have insurance that does not cover the full balance of the bill, and are unable to pay the bill, are encouraged to contact the Financial Services Representative who will use the Medicaid Eligibility Worksheet to determine whether you must apply for Medicaid/DSHS and provide you with the Medicaid application.
- **Charity Care/Sliding Fee Scale:** Patients who have been denied coverage by Medicaid, or who have a large spend down that they are not able to meet, may apply for the Sliding Fee Scale. Determination of eligibility for this program is based on verification of household income and family size. (Guidelines for program included in informational packet)

If you decide to choose one of the options above, please contact the Financial Services Representative's office at (360) 385-2200, ext. 2267.

Jefferson Healthcare will accept payment by cash, check, debit card or Visa, Master Card, Discover Card, or American Express credit cards. Payment may be made by telephone, mail or in person at the Financial Services Office. For your convenience, you may complete the form below to make your credit card payment if you wish to mail in your payment.

I hereby authorize Jefferson Healthcare to charge my balance to the credit card indicated below:

Patient Name: _____ Account #: _____

Card Holder's Name: _____

Circle: Visa Master Card Discover American Express Debit Card

Charge Card Number: _____

Visa Card Users please enter the 3 digit number located in the signature block on the back of your credit card: _____

Expiration Date: _____ Amount \$ _____

Signature _____ Date _____

Jefferson Healthcare
Hospital, Clinics, Home Health and Hospice, Diagnostic and Rehabilitation Services
Port Townsend, WA 98368
360-385-2200 X 2267_____

SLIDING FEE SCALE

What is a sliding fee?

Sliding fee refers to the reduction (i.e. slide) of our normal charge to a lower charge for services provided at Jefferson Healthcare.

How is a reduction in fee determined?

Sliding fee is determined based on your income level and the number of members in your household. Using this information, our staff computes the amount of sliding fee reduction based on Federal poverty guidelines. Jefferson Healthcare will reduce the amount of your patient responsibility on any outstanding balances owed by you or a named dependent in this application for basic health service, elective service will not be discounted.

How can I qualify for a sliding fee?

To qualify for sliding fee, you will need to provide us with three pieces of information. We will need to document your level of income, the number of members in your household, and proof of residency (you must reside more than 50% of the year in Jefferson County).

What type of documentation do I need to provide?

We will need a copy of page 1 of your most recent federal income tax return (Form 1040 or 1040A) and a copy of recent wage statements, unemployment or pay stubs a statement from your employer showing year to date earnings can be substituted for pay stubs if one is not available. Copies of birth certificates, social security cards, etc. may be substituted for members of household verification. A copy of your current WA State driver's license or current utility bill with your name and street address is also required. This information is only used for determining your eligibility for sliding fee discount and is held in strict confidence. Once approved the sliding fee reduction will be good for 6 months, if you continue to receive services, you may be asked to re-apply.

What happens if I don't provide the documentation?

We will compute your sliding fee discount based on your information provided. You will be asked to send in the required documents. Without this documentation, you will receive a bill for the full amount of the charges, which are due within 30 days from the date of service. If you need a return visit to our clinics in the future, we will require that documentation be on file to continue qualifying for the sliding fee discount. If the required documentation is not on file, you will be charged our usual charges for the services provided. **Qualifying must be updated on a semi-annual basis.**

ABOUT THE JEFFERSON HEALTHCARE SLIDING FEE SCALE

We offer a sliding fee scale for patients who have **no** health insurance or a limited plan and whose family income is below 300% of the federal poverty level.

It may be possible that you qualify for Medicaid or Basic Health Plan coverage, our staff will assist you in obtaining those applications. Medicaid ineligibility and/or Basic Health waiting list sign-up must be established before you will be eligible for our sliding fee. **Our Financial Services Representative will ask you a few questions to determine whether you might be eligible for these plans.**

If you are eligible for our sliding fee, charges for your services will be discounted. **Full fee will be charged until an assessment qualifying you for our sliding fee scale is completed.**

INCOME VERIFICATION

In order to qualify for our sliding fee, income for each person supported by the income must be verified. Please provide **written** verification for yourself and each applicable family member within **14 days**.

Below are examples of the kinds of documentation required to verify your household's income:

- Last years IRS 1040 form **and**
- A copy of last two month's pay stubs
- If unemployed, a copy of last two month's unemployment check stubs, or current pay stub from most recent employer (for the last 3 months)
- Copy of driver's license or document showing current WA street address
- Verification of disability income
- Award letter for public assistance, military allotments, scholarships, etc
- Court order or Support Enforcement receipt for child or spousal support
- If no income whatsoever, and you are being provided room and board by someone else, a letter stating this from the people providing your room and board.
- If you have none of the above, some written documentation of your income from savings or checking account records, journals of jobs and receipts etc. must be provided.

Jefferson Healthcare
 Hospital, Clinics, Home Health and Hospice, Diagnostic and Rehabilitation Services
 Port Townsend, WA 98368
 360-385-2200 X 2267

We offer services on a sliding fee scale. In order to determine if you qualify for the sliding fee scale, please provide the following information.

How many people are supported by this income? _____

Use the number of persons in your family who live in the same household and who share income, food and/or rent. That number includes you, your spouse, and/or any dependents.

FULL NAME	RELATIONSHIP TO YOU	SOURCE OF INCOME	EMPLOYER

Please include a current address here

How much MONTHLY gross income in your household and where it comes from:

Employment _____	Disability _____
Unemployment _____	Pension Funds _____
Self-Employment _____	Savings/Trusts _____
Social Security _____	VA Benefits _____
Child Support _____	Spousal Support _____
Public Assistance _____	Food Stamps _____
Housing Allowance _____	Training Stipends _____
Military Family Allotments _____	Scholarships/Grants _____
Allowance/Gifts _____	Other _____
Support from an Absent Family Member _____	

TOTAL MONTHLY INCOME \$ _____

To the best of my knowledge, the information given is true and correct. I give the Jefferson Healthcare Patient Accounts permission to verify information about my financial status. I understand this information must be provided to qualify for the sliding fee discount. If this information is not received within 14 days, then I understand that I will be billed the full fee for the visit, which will be due within 30 days from the date of service. I understand that Jefferson Healthcare may verify this information through other third party resources and I will not be charged for this.

Patient Name _____ **Patient Signature** _____
Please print full name

Parent Signature _____ **Date:** _____
(If applicable)

For office use only:
 Annual Income \$ _____ # in Household _____ Sliding Scale Level _____ Interviewers Initials _____
 Manager Approval _____ Administrator Approval _____

Jefferson Healthcare
Hospital, Clinics, Home Health and Hospice, Diagnostic and Rehabilitation Services
Port Townsend, WA 98368
360-385-2200 X 2267

DETERMINATION OF ELIGIBILITY FOR CHARITY CARE/SLIDING FEE SCALE

Date Application Received: _____ Date Application Approved/Denied: _____

Income Verified: Y / N Type of Verification: _____

Family Size Verified: Y / N Type of Verification: _____

Third Party Status: Y / N Type of Verification: _____

The applicant is approved with _____ % reduction in allowable charges. The amount provided as

Sliding Fee Scale is: \$ _____

Patient's share: \$ _____

Date of Service: _____ Amount: \$ _____ Patient Bal. \$ _____

_____ The applicant's request is denied for the following reason(s):

Date Applicant Notified: _____ Approved/Denied by: _____

APPEAL RIGHTS

You have thirty days from the date of this notice to appeal any charity determination. You may challenge the level of charity granted as well as complete denials. You must contact your Financial Services Representative who will schedule the appeal with the hospital Chief Financial Officer. Be prepared to substantiate facts previously submitted that were excluded from the determination due to lack of verification. If you have new, updated information to support your claim, bring it to the hearing.

The charity guidelines are straightforward, and determinations are made based upon the facts you submit. Special consideration may be granted when unusual circumstances of medical hardship exist. Be prepared to explain and substantiate unusual circumstances that may apply to your case. The Chief Financial Officer will decide the appeal and notify you of his decision within 7 calendar days. The Chief Financial Officer's decision is final. If he decides against you, he is required to notify the State of his decision. The State will review the facts of the case.

Jefferson Healthcare
Hospital, Clinics, Home Health and Hospice, Diagnostic and Rehabilitation Services
Port Townsend, WA 98368
360-385-2200 X 2267

PAYMENT AGREEMENT

PROVIDER/CLINIC/SERVICE: _____

PATIENT: _____

ACCOUNT NUMBER: _____

DATE(S) OF SERVICE: _____

GUARANTOR: _____

ADDRESS: _____ **PHONE:** _____

CITY, STATE, ZIP: _____

TOTAL BALANCE DUE: _____

DOWN PAYMENT: _____ **DATE RECEIVED:** _____

MONTHLY PAYMENT AMOUNT: _____

DUE DATE: _____

(We accept Cash, Check, Debit Card, Visa, MasterCard, Discover, and American Express)

I agree to be personally responsible for payment of services as outlined above.

Patient/Guarantor (Please Print)

Signature

Authorized by:

Date