Salem Health and Salem Health West Valley
Financial Assistance Administrative (Condensed) Policy and Application

Salem Health is committed to ensuring our patients get the medical care they need no matter their financial situation. You may qualify for free or discounted care based on your family size and income, even if you have health insurance. You may also be eligible for other government and community programs. We can help you learn whether these programs (including Oregon Health Plan) can help cover your medical bills and assist you in applying for these programs.

What is Covered? We provide free care or discounted care to eligible patients on a sliding fee scale basis, with discounts ranging from 25% to 100%, for emergency and other appropriate services at Salem Health Hospitals & Clinics. This program only covers medically necessary care provided at Salem Health Hospitals & Clinics. It does not cover any non-medically necessary procedures, any services deemed ineligible within the Financial Clearance policy, prescriptions or physician charges billed outside of Salem Health. Unpaid balances on all emergent and other medically necessary services are eligible for financial assistance. A patient who is eligible for financial assistance will not be charged more than amounts generally billed to patients who have insurance.

Financial Assistance Eligibility and Determination: You are eligible to apply for financial assistance any time prior, during, or after services are provided. Criteria considered in determining eligibility is based on your family size and household's* gross income based on Federal Poverty Guidelines (FPG). You may be eligible for Financial Assistance upon submission of an application as outlined below:

Financial Assistance Category	Percentage Discount
0-300% Income as a Percentage of Federal Poverty Level	100%
301-400% Income as a Percentage of Federal Poverty Level	65%
Catastrophic Discount	100% of balances greater than 20% Gross Family Income

*The definition of 'household's gross income' includes the combined gross monthly income of all persons legally responsible for patient bill or balance.

You will receive a determination letter or request for additional documents letter in the mail within 21 days after we receive your application. Any other potential sources of payment, such as state medical insurance, health share coop/cost sharing, liability insurance, workman's comp, etc. must be exhausted prior to receiving discounts. Financial assistance is the option of last resort, and you must cooperate with the approval process of any funding solution that would pay the patient's bills in order to be eligible for financial assistance.

Financial assistance determinations are valid for 12 months. Coverage will begin two years prior to the Salem Health receiving a completed financial assistance application and end the last day of the twelfth month from which the approval is processed. Financial assistance will be applied to accounts with open balances within this coverage period.

How to Apply for Financial Assistance: Any patient may apply by either submitting an application and providing supporting documentation through MyChart at www.salemhealth.org/fa-app, or by filling out the enclosed application in its entirety, including supporting required documentation listed below. Please **return to Salem Health, PO Box 14001, Salem, OR 97309.** You may also email to financial.counselors@salemhealth.org, fax to 503-814-1998, or drop off in person at the main hospital campus in Building A, 1st floor at the information desk or at West Valley main desk lobby.

Supporting documentation may include the following:

- Current year federal tax filing including all pages and schedules
- Non-filing verification letter from the IRS
- Most recent three (3) months wage stubs from your employer
- Current year Social Security Administration award letter
- Current year pension benefit award letter
- Veterans Affairs award letter
- Annuity award letter

- Unemployment benefits letter
- Child support award letter
- Alimony award letter or court documents
- Student financial aid award letter
- Short term disability benefits award letter
- Long term disability benefits award letter
- A "Basic Needs" letter that indicates how persons with no income are meeting their day-to-day basic living needs

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information. If your household does not have any types of income listed above, please contact our office at 503-562-4357 (option #3) to see if you may be eligible for the Oregon Health Plan and we can assist you in applying.

Translated versions of the application form, financial assistance policy, and summary, are available upon request in Spanish, Russian, and Chuukese. To obtain documents via mail free of charge, call 503-562-4357, or visit our website.

Presumptive Eligibility and Determination: Salem Health will screen any patient/guarantor 1) without public or private health insurance coverage, 2) enrolled in a state medical assistance program, or 3) who will owe the hospital $500 or more on a single statement, prior to them receiving a statement. We will also screen all patients prior to sending to collections.

Presumptive charity discounts are determined based on the Federal Poverty Guidelines (FPG) in accordance with Oregon House Bill 3076 and 3320. A charity scoring vendor is utilized to determine the Federal Poverty Level (FPL). There is no negative impact to the patient/guarantor's credit score in using the third-party software. Based on the result, the following adjustment will be applied to the account prior to receiving a billing statement:

Income as a percentage of Federal Poverty Level	Percentage Discount
Less than or equal to 200%	100%
201% - 300%	75%
301%-350%	50%
351%-400%	25%

If you have any questions, want to schedule an appointment, or would like further information, please contact us:

- By telephone: 503-562-4357
- Email: financial.counselors@salemhealth.org
- On our website at: http://www.salemhealth.org/financialassistance

Emergency Care: Salem Health has a dedicated emergency department and provides care for emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act) without discrimination consistent with available capabilities, without regard to whether a patient has the ability to pay or is eligible for financial assistance.

Applicable Providers: Financial assistance discounts will be applied to any balance(s) owed to Salem Health Hospitals & Clinics or employed providers of the Salem Health Medical Group. Non-employed providers rendering services within our facility are not required to honor our financial assistance determination.

Other Discounts and Options:

- **Uninsured discount:** We offer a 53% discount for patients who do not have health insurance coverage.
- **Payment plans:** Any balance for amounts owed by you is due within 30 days. The balance can be paid in any of the following ways: credit card, payment plan, cash, check, or online bill pay.
    - If you need a payment plan, please setup via MyChart or call the number on your billing statement, 503-814-2455.

Charity Care/Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION
Do you need an interpreter? ☐ **Yes** ☐ **No** *If Yes, list preferred language:*
Has the patient applied for Medicaid? ☐ **Yes** ☐ **No**
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 that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 21 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION			
Patient first name	Patient middle name		Patient last name
☐ Male ☐ Female ☐ Other (may specify ______________)	Birth Date		Patient Social Security Number (optional)
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional)
Mailing Address ________________________________ ________________________________ City State Zip Code			Main contact number(s) ( ) ________________ ( ) ________________ Email Address: ________________________
Employment status of person responsible for paying bill ☐ **Employed** (date of hire: ____________________) ☐ **Unemployed** (how long unemployed:______________________) ☐ **Self-Employed** ☐ **Student** ☐ **Disabled** ☐ **Retired** ☐ **Other** (______________________)			

FAMILY INFORMATION

Household means: a single individual; or spouses, domestic partners, or a parent and child under 18 years of age, living together; and other individuals for whom a single individual, spouse, domestic partner or parent is financially responsible.

FAMILY SIZE ___________ *Attach additional page if needed*

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?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

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*______________)

Charity Care/Financial Assistance Application Form – confidential

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 signed statement describing your income. Please provide proof for every identified source of income.
Examples of proof of income include:

- Current pay stubs (*3 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

(This section is optional and may be used to determine eligibility for other assistance programs)

Monthly Household Expenses:
Rent/mortgage $________________________ Medical expenses $________________________
Insurance Premiums $________________________ Utilities $________________________
Other Debt/Expenses $________________________ (*child support, loans, medications, other*)

ASSET INFORMATION

(This section is optional and may be used to determine eligibility for other assistance programs)

Current checking account balance $______________________________ Current savings account balance $______________________________	Does your family have these other assets? **Please check all that apply** □ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s) □ Property (excluding primary residence) □ Own a business

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.

PATIENT AGREEMENT

I understand that [*Hospital/system Name*] 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