Lake Health District

Policy Number: 9-895-203

Financial Services
Private Pay Services Policy
Date Issued: 10/07/1992

Date Revised: 06/07/2017

Approved by: _____ Administrator / CEO
Approved by: _____ Board of Directors
Approved by: _____ Chief Financial Officer

Lake Health District – Private Pay Services Policy

Policy:

Private Pay Services includes individuals who do not have insurance or have a balance remaining after insurance has paid.

Insurance companys may determine a service not to be medically necessary and as such not covered by insurance. In these cases the balance will be patient responsibility. Prepayment may be required prior to services rendered. Non-medically necessary services are not eligible for financial assistance through the hospital.

There are various discounts and help for this type of patients and they are listed below:

1. Private Pay Discount (15% if paid 30 days after initial statement)
2. Monthly Payment when all other options have been exhausted. (See minimum payment guidelines
3. OB/Newborn Pre-Payment Discount Policy (15% if paid within 90 day of initial statement)
4. Financial Assistance Program (FAP) (See Financial Assistance Guidelines)

Private Pay Discount:

Lake District Hospital offers a 15% private pay discount program for patients who do not have health insurance. A 15% discount is offered on all patient balances when paid in full within thirty days of the initial statement being mailed out.

Online Bill Pay

Lake District Hospital offers the opportunity to make payments through our secure website. Payments are posted within 48 hours.

Monthly Payment Guidelines:

Lake District Hospital will accept extended payments on accounts that have balances on patient accounts. The minimum monthly payment amount is based on the scheduled guidelines adopted by the Board of Directors.

In order to participate in the electronic Funds Transfer (EFT) program through Lake Health District, the guarantor must have valid bank account, provide a voided check, and sign both the EFT Payment Plan Guidelines and the EFT Authorization form, available from the Patient Services Representative. Please note that all information given to us is kept private and confidential.

Monthly EFT's can be made on the 5th, 15th, and 25th of every month. On the assigned date of payment, there will be an automatic withdrawal from the provided bank account. If the chosen day (s) falls on a weekend or bank holiday the transfer will be made on the next business day.

There will be a maximum of one default per calendar year allowed. This will be subject to an insufficient funds fee of $35. Should there be two defaults in one calendar year the account may be taken off of the EFT Monthly Payment Plan and/or may be transferred to a collection agency.

(See EFT Form Appendix A)

Monthly Payments Guidelines(continued):

Lake District Hospital will accept monthly payments when all other payment options have been exhausted. The minimum monthly payment amount is based on the scheduled guidelines below. Each visit is set up on a separate monthly payment plan account and minimum monthly payments are calculated on each account.

ACCOUNT BALANCE	MINIMUM MONTHLY PAYMENT/MONTHS FOR PAYOFF
Up to $50.00	Payment in Full
$51 to $2000	12 Months
$2001-$6,000	24 Months
$6,001-$15,000	48 Months
$15,000 and up	60 Months

An initial payment of 10% of balance is required to meet monthly payment guidelines

*PLEASE NOTE: Because Lake District Hospital is supported by county tax dollars, the Board of Directors established the minimum payment guideline policy in an effort to remain impartial. The Patient Services Representative does NOT have the authority to deviate from the established minimum payment schedule. If your minimum payment creates a financial hardship for your or your family you are advised to complete an application for financial assistance. You can obtain an application online or from the Business Office.

OB/Newborn Pre-Payment Discount Policy:

Lake District Hospital offers a discount program for expectant mothers who pre-register for delivery and newborn visits. A pre- payment of 50% of estimated patient balance is recommended. A 15% discount on patient balance will be applied if the patient balance is paid within 90 days of initial statement. For patients who have insurance coverage, the 15% discount is applied after the insurance has paid.

Financial Assistance Guidelines

Completion of Application

a.) The Financial Assistance Application may be printed from the Lake District Hospital website or received from the Business Office. Applications may be requested via mail.

b.) The completed application is required to be submitted within 120 days of initial statement. Incomplete applications will be returned with request of additional information. To continue application process additional information must be received within 14 days. If completed application is not received within 120 days of initial statement financial assistance will be denied and the normal collection process will continue.

c.) Lake District Hospital will make a determination on every application within 30 days of receipt of the completed application. Determination letters will be sent via mail.

d.) All information relating to the application for financial assistance will be kept confidential.

Eligibility Criteria

a.) Income Level Requirement

I. Patient eligibility for financial assistance is determined by measuring household income from all sources (i.e. gifts, housing allowances, sale of goods, etc.) against the income poverty guidelines established by the U.S. Department of Health and Human Services. A sliding fee scale will be used to determine financial assistance discounts when gross family income is at or below 200% of federal income poverty guidelines. Patients will be held responsible to pay balances based on this determination.

b.) Determination

I. Considerations for assistance include a review of responsible parties' annual income based on previous year's tax returns and other verifiable proof of income (pay stubs, bank statements …). Federal guidelines also consider the number of people living in a household.

II. Employment status should consider the likelihood of future earnings sufficient to meet the healthcare related obligation within a reasonable amount of time. Other financial obligations may be considered.

III. Should a patient require additional treatment without the ability to pay, the patient must request an additional review of their financial assistance application. Determinations may be valid up to 6 months beyond determination date.

IV. If requested, the District may require patients to provide verifiable proof that they have first applied for assistance with a State assistance agency (such as, State Health Plan, SSI or SSD) and have been denied.

V. Any account pending eligibility determination by another payer source will be excluded from consideration until such determination is made.

VI. Determination for assistance is based on applicant's current financial situation.

VII. Applications for the Financial Assistance Program are not restricted because of race, creed, sex, national origin, age, handicap or sexual orientation.

VIII. Non-medically necessary services are not eligible for financial assistance

IX. Collection policies regarding debt can be found on our website under document "Private Pay Services Policy".

X. This financial assistance application can be found at www.lakehealthdistrict.org and on site at Lake District Hospital.

FAP Application and guidelines are available in Spanish.

See Financial Assistance Application (Appendix B)

Lake District Hospital
700 South J Street
Lakeview, OR 97630
541-947-2114

Appendix "A"

EFT Guidelines

Lake District Hospital will accept extended payments on accounts that have balances after insurance has paid or for individuals that have no insurance. The balance after insurance has paid becomes patient responsibility. The minimum monthly payment amount is based on the scheduled guidelines adopted by the Board of Directors.

In order to participate in the electronic Funds Transfer (EFT) program through Lake Health District, the guarantor must have valid bank account, provide a voided check, and sign both the EFT Payment Plan Guidelines and the EFT Authorization form, available from the Patient Services Representative. Please note that all information given to us is kept private and confidential.

Monthly EFT's can be made on the 5th, 15th, and 25th of every month. On the assigned date of payment, there will be an automatic withdrawal from the provided bank account. If the chosen day (s) falls on a weekend or bank holiday the transfer will be made on the next business day.

There will be a maximum of one default per calendar year allowed. This will be subject to an insufficient funds fee of $35. Should there be two defaults in one calendar year the account may be taken off of the EFT Monthly Payment Plan and/or may be transferred to a collection agency.

I have read and understand the above statements.

_____ _____

(Signature of Account Holder) (Date)

_____ _____

(Print Name of Account Holder) (Account #)

Lake District Hospital
700 South J Street
Lakeview, OR 97630
541-947-2114

Appendix "A" (Continued)

Electronic Funds Transfer Authorization

I (we) hereby authorize Lake District Hospital, hereinafter called Lake District Hospital, to initiate debit entries to my (our) account indicated below and the financial institution named below, to debit the same to such account for payment on my (our) monthly payment plan. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

_____
(Financial Institution Name) (Branch)

_____
(Address) (City/State) (Zip)

_____ _____ Type of Acct: ____Checking ____ Savings
(Routing Number) (Account Number)

_____ Please Circle Date of Monthly Withdrawal: 5th 15th 25th
($ Amount)

This authority is to remain in full force and effect until Lake District Hospital has received written notification from me (or either of us) of its termination in such time and manner as to afford Lake District Hospital and my (our) financial institution a reasonable opportunity to act on it OR until there is no longer a balance with Lake District Hospital whichever comes first.

_____ _____
(Print Name of Account Holder) (Signature of Account Holder)

_____ _____
(Account Number) (Date)

PLEASE ATTACH COPY OF A VOIDED CHECK TO THIS FORM

Appendix" B"

Lake District Hospital

700 South J Street, Lakeview, OR 97630
(541)947-2114 ext 367

FINANCIAL ASSISTANCE GUIDELINES

Completion of Application

e.) The Financial Assistance Application may be printed from the Lake District Hospital website or received from the Business Office. Applications may be requested via mail.

f.) The completed application is required to be submitted within 120 days of initial statement. Incomplete applications will be returned with request of additional information. To continue application process additional information must be received within 14 days. If completed application is not received within 120 days of initial statement financial assistance will be denied and normal collection process will continue.

g.) Lake District Hospital will make determination on applications within 21 days of receipt of completed application. Determination letters will be sent via mail.

h.) All information relating to the application for financial assistance will be kept confidential.

Eligibility Criteria

c.) Income Level Requirement

I. Patient eligibility for financial assistance is determined by measuring household income from all sources (i.e. gifts, housing allowances, sale of goods, etc.) against the income poverty guidelines established by the U.S. Department of Health and Human Services. A sliding fee scale will be used to determine financial assistance discounts when gross family income is at or below 150% of federal income poverty guidelines. Patients will be held responsible to pay balances based on this determination.

d.) Determination

I. Considerations for assistance include a review of responsible parties' annual income based on previous year's tax returns and other verifiable proof of income (pay stubs, bank statements …) . Federal guidelines also consider number of people living in household.

II. Employment status should consider the likelihood of future earnings sufficient to meet the healthcare related obligation within a reasonable amount of time. Other financial obligations may be considered.

III. Should a patient require additional treatment without the ability to pay, the patient must request an additional review of their financial assistance application. Determinations may be valid up to 6 months beyond determination date.

IV. If requested, the district may require patients to provide verifiable proof that they have first applied for assistance with a State assistance agency (such as, State Health Plan, SSI or SSD) and have been denied.

V. Any account pending eligibility determination by another payer source will be excluded from consideration until such determination is made.

VI. Determination for assistance is based on applicant's current financial situation.

VII. Applications for the Financial Assistance Program are not restricted because of race, creed, sex, national origin, age, handicap or sexual orientation.

VIII. Non-medically necessary services are not eligible for financial assistance

IX. Collection policies regarding debt can be found on our website under document "Private Pay Services Policy"

X. This financial assistance application can be found at www.lakehealthdistrict.org and on site at Lake District Hospital

_____ _____

Guarantor Signature Date

*FAP Application and guidelines are available in Spanish upon request

Lake District Hospital

700 South J Street, Lakeview, OR 97630
(541)947-2114 ext 396

Guarantor's Information:

Guarantor's Name: Last, First, MI					Social Security Number
Date Of Birth	Account Number	Employer: Name, Address, Telephone			
Street Address	City	State	Zip Code	Telephone	
Mailing Address (If Different Than Above)	City	State	Zip Code	Marital Status ☐Married ☐Divorced ☐Single	

Household Information: Please indicate ALL people living in your household, including applicant

Please list anyone living in your household (including yourself). Income includes gross wages, salaries, tips, self-employment income, child support, alimony, rental income, unemployment compensation, social security benefits, public/government assistance, etc. (Income also includes rent or living expenses exchanged for services provided.)

Household Members	Date Of Birth	Relationship	Source of Income and/or Employer	Gross Annual Income
1.				$
2.				$
3.				$
4.				$
5.				$
6.				$

Federal Income Poverty Level 2015	100%	125%	150%	175%	200%	250%	275%	300%	325%	350%	375%	400%
% of Discount	100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%
1	11,880	14,850	17,820	20,790	23,760	29,700	32,670	35,640	38,610	41,580	44,550	47,520
2	16,020	20,025	24,030	28,035	32,040	40,050	44,055	48,060	52,065	56,070	60,075	64,080
3	20,160	25,200	30,240	35,280	40,320	50,400	55,440	60,480	65,520	70,560	75,600	80,640
4	24,300	30,375	36,450	42,525	48,600	60,750	66,825	72,900	78,975	85,050	91,125	97,200
5	28,440	35,550	42,660	49,770	56,880	71,100	78,210	85,320	92,430	99,540	106,650	113,760
6	32,580	40,725	48,870	57,015	65,160	81,450	89,595	97,740	105,885	114,030	122,175	130,320
7	36,730	45,913	55,095	64,278	73,460	91,825	101,008	110,190	119,373	128,555	137,738	146,920
8	40,890	51,113	61,335	71,558	81,780	102,225	112,448	122,670	132,893	143,115	153,338	163,560

I agree to pay $_____ per month against the medical bills incurred at Lake District Hospital, however I understand that the payment required will be determined by Lake District Hospital.

I certify the above information is true and correct to the best of my knowledge. I understand that the information which I submit is subject to verification and hereby authorize any party contacted by Lake District Hospital to release the requested verification to the hospital.

_____ _____

Guarantor Signature Date