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Last Revised	11/2026		
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Charity Care Policy

I. SCOPE:

This policy applies to all patients of Summit Pacific Medical Center (SPMC).

II. PURPOSE:

Summit Pacific Medical Center (SPMC) is committed to the provision of health care services to all persons in need of medical attention regardless of ability to pay. To protect the integrity of operations and fulfill this commitment, the following criteria for the provisions of Charity Care, consistent with the requirements of Washington Administrative Code (WAC) 246-453, are established. These criteria will assist staff in making consistent and objective decisions regarding eligibility for Charity Care while ensuring the maintenance of a sound financial basis.

The written policy includes: (a) eligibility criteria for Charity Care, (b) describes the basis for calculating amounts charged to patients eligible for Charity Care (c) describes the method by which patients may apply for Charity Care and (d) describes how SPMC will publicize the policy with the community serviced by SPMC.

III. POLICY:

Charity Care may cover all appropriate medical services, received at SPMC hospital or outpatient/clinic setting. Services not qualifying under Charity Care may include transportation costs or elective services provided by SPMC.

IV. PROCEDURE/REQUIREMENTS OF POLICY:

ELIGIBILITY CRITERIA

Charity Care is 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.

Does not discriminate in the provision of services to an individual (i) because the individual is unable to pay; (ii) because payment for those services would be made under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP); or (iii) based upon the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. [May or may not be applicable to Indian Health Service, Tribal or Urban Indian Health Clinics (ITUs), free clinics, or correctional facilities].

In those situations where, appropriate primary payment sources are not available, patients shall be considered for Charity Care under this policy based on the following criteria consistent with requirements of WAC 246-453-040:

A. The full amount of patient or guarantor responsibility for charges will be determined to be charity care for a patient or their guarantor whose income is at or below 200% of the current federal poverty level, adjusted for family size (consistent with WAC code 246-453-050). These patients shall receive a 100% adjustment on their patient balance.
    - SPMC will not consider the value of assets to reduce charity care discounts for individuals in this category.

B. 75% of patient or guarantor responsibility for charges will be determined to be charity care for a patient or their guarantor whose income is between 201% and 250% of the current federal poverty level, adjusted for family size, for the current year. The guidelines shall take into account the potential necessity for allowing the responsible party to satisfy the maximum amount of charges for which the responsible party will be expected to provide payment over a reasonable period of time, without interest or late fees. In determining the maximum amount of charges, SPMC calculates this by using the Amounts Generally Billed (AGB) look-back methodology. For the previous years, SPMC's AGB percentage is listed on **Attachment A.** No individual qualifying under the Charity Care Policy shall be charged more than the AGB for emergency care or other medically necessary services.
    - SPMC will not consider the value of assets to reduce charity care discounts for individuals in this category.

C. 50% of patient or guarantor responsibility for charges will be determined to be charity care for a patient or their guarantor whose income is between 251% and 300% of the current federal poverty level, adjusted for family size.
    - SPMC will not consider the value of assets to reduce charity care discounts for individuals in this category.

MEDICAID AND HEALTH BENEFIT EXCHANGE OBLIGATIONS

Identification of Patients Eligible for Certain Third-Party Coverage: For services provided to patients on or after July 1, 2022, the following procedures will apply for identifying patients and/or their guarantors who may be eligible for health care coverage through Washington medical assistance programs (e.g., Apple Health).

A. As a part of the charity care application process for determining eligibility for Charity Care, SPMC will query as to whether a patient or their guarantor meets the criteria for health care coverage under medical assistance programs under chapter 74.09 RCW or the Washington Health Benefit Exchange.

B. If information in the application indicates that the patient or their guarantor is eligible for coverage, SPMC will assist the patient or their guarantor in applying by, among other things:

    1. Helping individuals and families complete their *Washington Healthplanfinder* application and enroll in health insurance coverage,
    2. Supporting individuals with cultural, linguistic, disability, or other special needs, and
    3. Explaining coverage options and the availability of Charity Care to lower the cost of insurance premiums
        1. In providing assistance to the application process, SPMC will take into account any physical, mental, intellectual, sensory deficiencies or language barriers which may hinder either the patient or their guarantor from complying with the application procedures and will not impose procedures on the patient or guarantor that would constitute an unreasonable burden.

C. If the patient or guarantor fails to make reasonable efforts to cooperate with SPMC in applying for coverage under chapter 74.09 RCW, SPMC is not obligated to provide charity care to such patient.

D. If a patient or their guarantor is obviously or categorically ineligible or has been deemed ineligible for coverage through medical assistance programs under chapter 74.09 RCW or the Washington Health Benefit Exchange in the prior 12 months, SPMC will not require the patient or their guarantor to apply for such coverage.

CATASTROPHIC CHARITY CARE

SPMC may also write off as Charity Care amounts for patients with family income in excess of 300% of the federal poverty standards or at a higher percentage for those above 200% of the poverty guidelines, when circumstances indicate severe financial hardship or personal loss. This will be done only upon recommendation by patient account representatives, revenue manager or our billing office, InlandRCM, with adequate justification and only upon approval by the Chief Financial Officer.

PROCESS FOR ELIGIBILITY DETERMINATION

Initial Determination

For the purpose of reaching an initial determination of eligibility, SPMC shall rely upon information provided orally or in written form for Charity Care as outlined in the Charity Care / Financial Assistance Application form instructions. SPMC may require the responsible party to sign a statement attesting to the accuracy of the information provided to SPMC for purposes of the initial determination of eligibility. Pending final eligibility determination, SPMC will not initiate collection efforts or requests deposits, provided that the responsible party is cooperative with SPMC's efforts to reach a determination of sponsorship status, including return of applications and adequate documentation. SPMC shall use an application process for determining initial interest in and qualification for Charity Care. Should patients not choose to apply for Charity Care, they shall not be considered for Charity Care unless other circumstances become known to SPMC.

Requests to provide Charity Care will be accepted from sources such as a physician, community or religious groups, social services, financial services personnel, or the patient. If SPMC becomes aware of factors which might qualify the patient for Charity Care under this policy, it shall advise the patient/ guarantor of the potential and make an initial determination that such account is to be treated as Charity Care.

Final Determinations

Charity Care forms, instructions, and written applications shall be furnished to patients when Charity Care is requested, when need is indicated, or when financial screening indicates potential need. Applications, whether initiated by the patient or SPMC should be accompanied by documentation to verify income amounts indicated on the application form. One or more of the following types of documentation may be acceptable for purpose of verifying income:

1. W-2 withholding statements for all employment during the relevant time period.
2. Pay stubs from all employment during the relevant time period.
3. An income tax return from the most recently filed calendar year.
4. Forms approving or denying unemployment compensation; or
5. Written statements from employers or welfare agencies. Patients will be asked to provide verification of ineligibility for Medicaid or Medical Assistance. During the initial request period, SPMC may pursue other sources of funding, including Medicaid.
6. In the event that the patient is not able to provide any of the documentation described above, SPMC shall rely upon written and signed statements from the patient for making a final determination of eligibility for purposes of granting Charity Care.

Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. This process will be determined by SPMC and will take into consideration seasonal employment and temporary increases and/or decreases of income. Applications will be processed within 14 days of receipt of the application to our billing office, InlandRCM.

Charity Care will be granted based on the approval guidelines. The initial determination shall remain valid for twelve (12) months. After that, SPMC may request updated information or re-verification of the patient's qualification status.

Patients may be asked to provide verification or eligibility for Apple Health or other Medical Assistance.

During the initial request period, SPMC may pursue other sources of funding, including Medicaid.

Income verification is required as outlined in SPMC's Charity Care Application form instructions.

For elective services not covered please contact SPMC or our billing office, InlandRCM.

In the event of non-payment or a patient does not reasonably cooperate with the Charity Care process, SPMC may take actions as outlined in its Patient Billing and Collection Policy, which is available by request and online.

Approvals

Charity Care applications will be approved once all required information is received and the income guidelines for granting Charity Care have been met. Applications will be processed within 14 days of receiving the application in the Business Office.

Eligibility on a completed and approved application is valid for eligible services received within the subsequent (180) days from application approval date and will be retroactive for eligible services for all dates of service that the Charity Care is being granted.

In the event that a responsible party pays a portion of all of the charges related to appropriate hospital-based medical care services, and is subsequently found to have met the Charity Care criteria at the time that services were provided, any payments in excess of the amount determined to be appropriate in accordance with WAC 246-453-020 shall be refunded to the patient within thirty days of achieving the Charity Care designation.

Time Frame for Final Determination and Appeals
SPMC shall provide final determination within fourteen (14) days of receipt of all application and documentation material.

Denials
When a patient's application for Charity Care is denied, the patient will receive a written notice of denial which includes:

- The reason or reasons for the denial and the rules to support SPMC's decision.
- The date of the decision; and
- Instructions for appeal or reconsideration.

When the applicant does not provide requested information and there is not enough information available for SPMC to determine eligibility, the denial notice also includes:

- A description of the information that was requested and not provided, including the date the information was requested.
- A statement that eligibility for Charity Care cannot be established based on information available to SPMC; and
- That eligibility will be determined if, within thirty days from the date of the denial notice, the applicant provides all specified information previously requested but not provided.

Denials will be written and include instructions for appeal or reconsideration as follows.

The patient/guarantor may appeal the determination of eligibility for by providing additional verification of income and family size to our billing office, InlandRCM, within (30) calendar days. After the first fourteen (14) days of this period, if no appeal has been filed, SPMC may initiate collection activities.

If SPMC has initiated collection activities and discovers an appeal has been filed, they shall cease collection efforts until the appeal is finalized. All appeals will be reviewed by our billing office, InlandRCM.

If this determination affirms the previous denial of Charity Care, written notification will be sent to the patient/guarantor and the Department of Health in accordance with state law.

DOCUMENTATION AND RECORDS

A. 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.

B. Documents pertaining to Charity Care shall be retained for six (6) years.

PROCESS FOR COMMUNICATION

SPMC's Charity Care Policy shall be made publicly available through the following elements:

A. Notices Posted or prominently displayed within public areas of SPMC advising patients that Charity Care is provided.

B. Written Notice of the availability of Charity Care will be made available to all patients. This is done at the time that SPMC requests information about pertaining to third party coverage. This written information shall also be verbally explained at this time. If for some reason, for example in an emergency situation, the patient is not notified of the existence of the Charity Care policy before receiving treatment, patient/guarantor shall be notified as soon as possible thereafter.

C. Written information about SPMC's Charity Care policy shall be made available to any person who requests the information.

D. SPMC shall train front-line staff to answer Charity Care questions effectively or direct such inquiries to our billing office, InlandRCM, in a timely manner.

DEFINITIONS

- 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.
- Income includes: gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation, Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.

A. Attachment: Amount Generally Billed (AGB)

SPMC uses the “look-back” method to calculate the 'amount generally billed’ (AGB) as required by federal law. The AGB is the maximum amount we will collect from a patient who is eligible for Charity Care under our Charity Care policy. The AGB percentage is based on all claims allowed by Medicare, Medicaid and health insurers over a 12-month period, divided by the associated gross charges for those claims.

For the period JAN 1, 2025, to DEC 31, 2025, SPMC billed $249,841,720 in gross charges to Medicare, Medicaid, and other health insurers, of which $112, 107,290 in claims were allowed. This makes the AGB 44.9%.

Calculation: $112,107,290 divided by $249,841,720 equals 44.9%

Approval Signatures

Step Description	Approver	Date
Executive	Cheryl Cornwell: Chief Financial Officer	11/2026
Policy Committee	Angelique Gerber: Executive Assistant	11/2026
Policy Owner	Cinthya Schuder: DIrector, Revenue Cycle	11/2026