



Subject: Providence Financial Assistance (Charity Care) Policy – Oregon	Policy Number: PSJH RCM 002 OR	
Department: Revenue Cycle Management	<input type="checkbox"/> New <input checked="" type="checkbox"/> Reviewed <input type="checkbox"/> Revised	Date: 12/1/2025
Executive Sponsor: SVP Chief Revenue Cycle Officer	Policy Owner: AVP, Financial Counseling	
Approved by: SVP Chief Revenue Cycle Officer	Implementation Date: 4/29/2025	

Providence is a Catholic not-for-profit healthcare organization that is dedicated to its Mission of serving everyone, especially those who are poor and vulnerable. Providence believes that getting medical care is a right every person should have. Providence makes sure that emergent and medically necessary healthcare services are available to anyone in the community, even if they can't afford to pay.

SCOPE:

This policy applies to all Providence hospitals and clinics (“Providence”) in the State of Oregon. It covers all emergency, urgent and other medically necessary services (with exception of experimental, investigative, aesthetic, or cosmetic care, or care for patient or physician convenience) (as defined in the definition of “Eligible Services”). You can see which Providence hospitals are included and how clinics are defined under this policy in Exhibit A. When we use the word “facility” in this policy, it refers to the full scope of facilities described in Exhibit A. Otherwise, the use of the words “hospital” or “clinic” refers to the specific meaning set forth in Exhibit A.

This policy shall be interpreted in a manner consistent with Section 501(r) of the Internal Revenue Code of 1986, as amended, and with the applicable Chapters of the Oregon Revised Statutes and Oregon Health Authority regulations, as amended. If this policy and the law ever conflict, the law will be followed.

PURPOSE:

The purpose of this policy is to ensure there is a consistent, fair, and non-discriminatory method for providing financial assistance (also referred to as “charity care”) to eligible individuals who cannot afford to pay, in full or part, for the Eligible Services provided by Providence facilities.

This policy is intended to comply with all applicable laws. This is the official Financial Assistance (Charity Care) Policy (FAP) and Emergency Medical Care Policy for each facility that is part of Providence in Oregon.

RESPONSIBLE PERSONS:

Revenue Cycle Departments. Also, all appropriate staff who perform functions relating to registration, admissions, financial counseling, and customer support will receive regular training on this policy.

POLICY:

Providence will provide Eligible Services at no cost, or at a lower cost, to qualifying patients who either submit an application or are deemed to be presumptively eligible for charity care, consistent with the criteria set out in this policy. Patients must meet the eligibility requirements described in this policy to qualify. For purposes of this policy, the term “patient” will be used to refer to the patient as well as any person who is a guarantor or responsible party on an account for a patient (i.e., an individual who is responsible for the payment of any facility charges on behalf of the patient which are not paid by a third party).

Providence hospital emergency departments will provide care for emergency medical conditions (within the meaning of the Emergency Medical Treatment and Labor Act) consistent with the emergency department’s available capabilities, regardless of whether an individual is eligible for financial assistance. Providence will not



discriminate based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, disability, veteran or military status, or any combination thereof, or any other basis prohibited by applicable law when making financial assistance determinations. Discrimination on the basis of sex includes, but is not limited to: sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes.

Providence hospitals emergency departments will provide emergency medical screening examinations and stabilizing treatment or, where appropriate, will refer and transfer an individual to another hospital. Providence does not allow any actions, admission practices, or policies that would discourage individuals from seeking emergency medical care, such as permitting debt collection activities that interfere with the provision of emergency medical care.

List of Professionals Subject to Providence FAP: Each Providence facility has a list of those physicians, medical groups, or other healthcare providers who are and who are not covered by this policy. Each Providence facility will provide this list to any patient who requests a copy. The provider list can also be found online at the Providence website: www.providence.org/financialhelp

Financial Assistance Eligibility Requirements: Financial assistance is available to both uninsured and insured patients if they meet the requirements of this policy. Charity care granted consistent with this policy is intended to also comply with other laws regarding permissible benefits to patients. Providence will make efforts to see if there is any other insurance that could cover the costs of the Eligible Services prior to billing the patient. Patients will not be required to apply for third-party medical assistance programs before being screened for financial assistance. Patients without insurance will receive a discount. The types of bills that might be eligible for financial assistance adjustments include, but are not limited to: self-pay, charges for patients with out-of-network coverage, and coinsurance, deductible, and copayment amounts related to insured patients.

Patients seeking financial assistance may complete the standard Providence Financial Assistance Application, and eligibility will be based upon financial need at that time. Efforts will be made to inform patients of the availability of financial assistance by providing information during admission and discharge, on the patient's billing statement, in patient accessible billing areas (like registration counters), on Providence's website, by oral notification during payment discussions, as well as on signage in inpatient and outpatient areas, including areas where patients are admitted or registered and in the emergency department. Providence will keep records of the information used to determine financial assistance eligibility. Providence will provide a paper copy of this policy to a patient upon request.

Providence will also approve certain patients for a charity adjustment to their account balance by means other than a full Financial Assistance Application if the patients meet the requirements detailed later in this policy (please see "Financial Assistance Without a Financial Assistance Application").

Applying for Financial Assistance: Patients may request and submit a Financial Assistance Application, which is free of charge and available at the Providence facility, or by the following means: advising patient financial services staff at or prior to the time of discharge that assistance is requested, by mail, or by visiting www.providence.org/financialhelp. A person's application for financial assistance will be processed to determine if they may meet the criteria for financial assistance as set forth in this policy.

Providence facilities have designated staff ready to help patients complete the Financial Assistance Application and see if the patient qualifies for financial assistance from Providence itself or from government-funded insurance programs. Help with language translation is also available to address any questions and to assist in the completion of the Financial Assistance Application.

A patient may provide a completed Financial Assistance Application, including all requested supporting documentation, at any time. Providence will suspend any collection activities pending an initial determination of eligibility for financial assistance, provided that the patient is cooperative with Providence's reasonable efforts to reach an initial determination. If Providence approves a patient's Financial Assistance Application, it will treat Eligible Services the patient receives as eligible for financial assistance for at least nine (9) months, unless the patient notifies Providence that they no longer need and/or want financial assistance.

A determination of eligibility for financial assistance can be made when a patient's income is at or below 400% of the FPL guidelines, adjusted for family size.



Individual Financial Situation: A patient's income and expenses will be used in assessing the patient's individual financial situation. Additionally, Providence will consider and collect information related to assets as required by the Centers for Medicare and Medicaid Services (CMS) for Medicare cost reporting, which applies to Medicare patients who do not also have Medicaid insurance. While Providence does collect asset information from such individuals, which may include bank statements, and other information that Providence's financial counselors believe is needed, not all such assets will figure into the final amount of the award. For instance, the calculation of the award will not consider: (A) the first \$100,000 of a patient's monetary assets (including their family's assets, if applicable), and 50% of a patient's monetary assets over the first \$100,000 (including their family's assets, if applicable); (B) any equity in a primary residence; (C) retirement or deferred compensation plans qualified under the Internal Revenue Code or nonqualified deferred compensation plans; (D) one motor vehicle and a second motor vehicle if it is necessary for employment or medical purposes; (E) any prepaid burial contract or burial plot; and (F) any life insurance policy with a face value of \$10,000 or less. The value of any asset that has a penalty for early withdrawal shall be the value of the asset after the penalty has been paid. Information requests from Providence to the responsible party to verify assets will be limited to that which is reasonably necessary and readily available to determine the existence, availability, and value of a person's assets and will not be used to discourage application for free or discounted care. Duplicate forms of verification will not be requested. Only one current account statement will be required to verify monetary assets. For individuals who are not Medicare beneficiaries, or for individuals who have both Medicare and Medicaid insurance, no asset information will be collected or evaluated.

Income Qualifications: The patient's income, based on FPL, may be used to determine eligibility for financial assistance. Please see Exhibit B for details.

Eligibility Determinations: Patients will receive notification of FAP eligibility determination within 30 days of submission of the completed Financial Assistance Application and necessary documentation. The notification will be delivered separately and in addition to any financial assistance statements included on billing statements. The notification will specifically include an explanation of the basis for the determination and will specify whether the application was incomplete, denied, accepted in full, or accepted with a patient cost adjustment for less than 100% of the patient costs.

- **Incomplete:** If an application is found to be incomplete, missing documentation, or containing errors, the application will be designated as incomplete and requiring further action by the patient. The notice will describe the deficiencies and actions the patient can take to complete the application by correcting the deficiencies. Providence will not make eligibility determinations based upon information contained in or submitted with an application that the facility reasonably believes is incorrect or unreliable.
- **Denied:** If an application was denied based on a failure to meet eligibility criteria, the notice will specify the specific eligibility criteria and provide contact information so the patient can request further information about the denial.

The notification will include a clear description of how the patient may request an appeal, in addition to the contact information of a Providence representative who can answer questions about the appeals process, which is described in further detail below.

Appeals Process: Patients who have completed a Financial Assistance Application may appeal a determination of ineligibility or of partial eligibility. Providence will notify the patient of their ability to appeal the determination within ten (10) business days of making the determination. If a patient requests an appeal, Providence will provide the patient with confirmation of receipt of the appeal request.

The patient may need to provide relevant additional documentation in support of their appeal. An appeal may be sent to Providence at the address listed, and in other ways described in the notice of determination letter.

Further, the patient may request review by Providence's Chief Financial Officer or his/her designee. Providence will issue a written determination on the appeal within 30-days of either the date of the final appeals review or the date of receipt of corrections related to the application deficiencies, whichever is later. If appeal is denied, there will be a secondary review by leadership before the denial is upheld.

During the pendency of an appeal, Providence will suspend all collection activities if collection activities have been initiated and will notify any collection agencies to suspend collection activities, if applicable. If the final appeal determination results in a denial of financial assistance or a decision that only partial assistance is



approved, Providence will notify the patient of the date on which suspended collection activities, if any, will resume. A patient who has taken corrective action on an application that was determined to have deficiencies may request an appeal if the application is subsequently denied based on a failure to meet the eligibility criteria.

Financial Assistance Without a Financial Assistance Application (Pre-Billing Screening):

Providence may approve a patient for a charity adjustment to his or her account balance without a full Financial Assistance Application as outlined in the circumstances below, which is known as “presumptive eligibility” determinations:

Hospital Services Only: Prior to engaging in a presumptive eligibility determination related to a patient receiving hospital services, a hospital will look to see if during the previous nine (9) month period the patient has applied for financial assistance and was found to be eligible based on documentation provided. If yes, the patient will receive a cost adjustment before receiving a billing statement. If not, the hospital will proactively screen (“prescreen”) patients as described more below to determine whether the patient qualifies as presumptively eligible for financial assistance. Prescreening and resulting adjustments to patient costs will also be completed prior to the hospital sending a patient a billing statement for the applicable hospital services. The hospital will notify the patient in writing of the results of the prescreening process, regardless of outcome, and will explain how to apply for financial assistance if it is still needed.

A patient will be reviewed for presumptive eligibility for financial assistance Eligible Services provided by a hospital if the patient: (i) is uninsured; (ii) is enrolled in a state medical assistance program, such as the Oregon Health Plan or other Oregon Health Authority programs; or (iii) owes the hospital more than \$500 after all adjustments from insurance or third-party payers. Hospitals may, but are not required to, use existing patient data in the presumptive eligibility determination process, including but not limited to:

- Existing patient records
- Information routinely collected during patient registration or admission
- Information voluntarily supplied by the patient
- Previous financial assistance adjustments, and
- Patient participation in other assistance programs (e.g., Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); Children's Health Insurance Program (CHIP); Women, Infants and Children (WIC); free lunch or breakfast programs; and low-income home energy assistance programs).

The presumptive eligibility determination process will use Experian, an industry-recognized financial assessment tool, to evaluate, for each account a patient has, that patient’s approximate household income and household size according to the eligibility criteria set forth in Exhibit B. The financial assessment tool will not cause any negative impact on the patient’s credit score. Patients will not be required to provide any separate supporting documentation as part of the presumptive eligibility determination process but may provide such documentation voluntarily. If Providence’s process fails to return information about the patient, Providence will make a good faith effort to determine the patient’s presumptive eligibility status based on other information available to the hospital. Providence will document the methods it utilized to conduct the presumptive eligibility screening.

For patients that are presumptively determined to be eligible for write-offs based on this prescreening, eligible amounts will be written off as shown on Exhibit B. Patients that are presumptively qualified eligible for financial assistance may voluntarily decline the presumptive eligibility award and be given the opportunity to pay by requesting verbally or providing written notification. The declination will be honored for a duration of nine (9) months from the date of notification. The patient may revoke the declination of award and/or apply for financial assistance by application at any time. Any payments made during the declination period will not be refunded. If a patient is not determined to be presumptively eligible for 100% of the patient cost amount, the patient may still apply for financial assistance by using the Financial Assistance Application.

Clinic Services Only: Free-standing clinics that are not part of the hospital will not prescreen patients but may otherwise approve a patient later for an adjustment on a presumptive basis if the patient meets the eligibility criteria outlined in the “Billing and Collections” section below. Any resulting adjustments to patient costs will be completed at the end of the billing cycle for the applicable clinic services before referring those costs to collections.

Catastrophic Medical Expenses: Providence will grant financial assistance in the event of a qualifying catastrophic medical expense at Providence’s discretion to grant additional assistance based on the patient’s



circumstances or if a patient's annual family income and total medical expenses at Providence facilities in the prior 12 months meet the requirements specified in Exhibit B. A complete Financial Assistance Application is required to be evaluated for eligibility for Catastrophic Medical Expenses.

Times of Emergency: Financial assistance may be available in times of a national or state emergency, independent of assistance for catastrophic expenses. Eligibility criteria and discount amounts will be set at Providence's discretion at the time of such emergency. A complete Financial Assistance Application is required to be evaluated for eligibility for Financial Assistance during Times of Emergency.

Eligibility Requirements: Providence may deny a patient's Financial Assistance Application when the patient or other responsible party fails to meet the requirements outlined in this policy. For patients that are not prescreened based on the process described above, Providence may, consistent with state law, impose eligibility requirements for financial assistance determinations without a Financial Assistance Application, including but not limited to requirements that patients respond to requests as necessary for their primary insurer to adjudicate a claim for reimbursement and that they provide information concerning any potential third party liability for the cost of services. If a patient does not qualify for financial assistance based on information considered without a complete Financial Assistance Application, the patient may still provide the required information pursuant to the Financial Assistance Application and be considered under the financial assistance eligibility and application process set forth in this policy.

Limitation on Charges for all Patients Eligible for Financial Assistance: No patient who qualifies for any of the above-noted categories of financial assistance will be charged more than the Amounts Generally Billed (AGB) percentage of gross charges for Eligible Services, as defined below.

Reasonable Payment Plan: All patients can request a payment plan, regardless of financial assistance determination or application. The payment plan will include monthly payments (without interest or late fees) that are not more than 10% of a patient's or their family's monthly income, minus the patient's usual living costs as listed on the patient's Financial Assistance Application.

Billing and Collections (Pre-Collections Screening): If there are any amounts left to pay after application of eligible financial assistance, the amounts may be referred to collections, except that Providence will not refer amounts for Eligible Services provided to Medicaid beneficiaries to collections. Providence will conduct a pre-collect screening to determine if the patient qualifies for presumptive eligibility before referring an unpaid charge for collections as shown on Exhibit B. If a patient applies for financial assistance after being referred to collections, collection efforts on unpaid balances will cease pending final determination of financial assistance eligibility. Providence will not take, or allow collection agencies to take, any Extraordinary Collection Actions, as defined below. For information on Providence billing and collections practices for amounts owed by patients, please see Providence's "Patient Bad Debt Assignments" policy, which is available free of charge at each Providence's registration desk or at: www.providence.org/billing-support/understand-bill.

Patient Refunds: If a patient pays for Eligible Services and is later found eligible for financial assistance based on financial assistance application, any payments made for those Eligible Services during the FAP-Eligible Time Period that exceed the payment obligation will be refunded by Providence. For clarity, Providence will not automatically refund amounts previously paid based on a presumptive eligibility determination. If Providence was previously incorrect in its determination that the patient did not qualify for financial assistance based on information provided by the patient at the time of the incorrect determination, Providence will also pay interest on the amount of financial assistance at the rate set by the Federal Reserve and other associated reasonable costs. If Providence transferred the debt to a collection agency, Providence will notify the collection agency that the debt is invalid.

Annual Review: This policy will be reviewed annually by designated Revenue Cycle leadership.

EXCEPTIONS:

See Scope above.

DEFINITIONS:

The following definitions and requirements apply to this policy:



1. Federal Poverty Level (FPL): FPL means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services.
2. Amounts Generally Billed (AGB): The amounts generally billed for emergency and other medically necessary care to patients who have health insurance is referred to in this policy as AGB. Providence determines the applicable AGB percentage for each Providence facility by multiplying the facility's gross charges for the Eligible Services by a fixed percentage that is based on claims allowed under Medicare or commercial payors. Information sheets detailing the AGB percentages used by each Providence facility, and how they are calculated, can be obtained by visiting the following website: www.providence.org/financialhelp or by calling 1-866-747-2455 to request a copy.
3. Eligible Services: Eligible Services means the emergency or medically necessary services provided by a Providence facility that are eligible for financial assistance. Medically necessary services, for purposes of this policy, include services to prevent, diagnose, or treat an illness, injury, condition, or disease, or the symptoms of an illness, injury, condition, or disease, and that meet accepted standards of medicine. Services that are aesthetic, cosmetic, experimental, investigative, or part of a clinical research program, or services that are for patient or physician convenience, are not considered medically necessary services.
4. Extraordinary Collection Action (ECA): ECAs are defined as those actions that require a legal or judicial process, involve selling a debt to another party, or involve reporting adverse information to credit agencies or bureaus. The actions that require legal or judicial process for this purpose include a lien; foreclosure on real property; attachment or seizure of a bank account or other personal property; commencement of a civil action against an individual; actions that cause an individual's arrest; actions that cause an individual to be subject to body attachment; and wage garnishment.
5. FAP-Eligible Time Period: The FAP-Eligible Time Period for (i) hospital services is the 240-day period of time; and (ii) clinic services is the 90-day period, in each case that a patient has to submit a Financial Assistance Application to Providence. The timing begins on the date the first post-discharge billing statement is provided to the patient. A billing statement is considered "post-discharge" if it is provided to a patient after the patient received care, whether inpatient or outpatient, and the individual has left the facility. A separate FAP-Eligible Time Period starts with each episode of care, and the 240-day period for hospital services or 90-day period for clinic services, as applicable, will be measured from the first post-discharge bill for the most recent episode of care. That said, Providence has the discretion to accept and process Financial Assistance Applications from patients at any time.

REFERENCES:

<i>Internal Revenue Code Section 501(r); 26 C.F.R. 1.501(r)(1) – 1.501(r)(7)</i>
<i>Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd</i>
<i>42 C.F.R. 482.5, 482.55 and 413.89</i>
<i>American Hospital Associations Charity Guidelines</i>
<i>Providence Commitment to the Uninsured Guidelines</i>
<i>Provider Reimbursement Manual, Part I, Chapter 3, Section 312</i>
<i>O.R.S. § 442.610(2), § 442.610(3)</i>
<i>O.R.S, § 442.614</i>
<i>O.R.S. § 442.615</i>
<i>O.R.S. § 646A.677</i>
<i>O.A.R. 409-023-0115, 409-023-0120, 409-023-0125</i>



Exhibit A – Covered Facilities List

This policy applies to all covered facility inpatient and outpatient departments and clinics. In addition, this policy applies to the employees of covered facilities, as well as any not-for-profit or non-profit entity majority owned or controlled by Providence and bearing the Providence name and their respective employees.

Providence Hospitals in Oregon	
Providence Hood River Memorial Hospital	Providence Medford Medical Center
Providence Milwaukie Medical Center	Providence Newberg Medical Center
Providence Willamette Falls Medical Center	Providence Portland Medical Center
Providence St. Vincent Medical Center	Providence Seaside Hospital

Providence Clinics in Oregon. means all outpatient clinics in Oregon that are owned in whole or part by a Providence hospital, operating under the common control of a Providence hospital, or operating under the Providence brand.



Exhibit B - Income Qualifications for Providence Hospitals in Oregon

If...	Then....
<p>If a patient has submitted a complete Financial Assistance Application as outlined in this policy and the annual family income, adjusted for family size, is at or below 300% of the current FPL guidelines,</p>	<p>The patient is determined to be financially indigent and qualifies for financial assistance 100% write-off on patient responsibility amounts for Eligible Services.</p>
<p>If a patient has submitted a complete Financial Assistance Application as outlined in this policy and the annual family income, adjusted for family size, is between 301% and 400% of the current FPL guidelines,</p>	<p>The patient is eligible for a discount of 70% from original charges on patient responsibility amounts for Eligible Services, and in no event will be charged in excess of AGB.</p>
<p>If a patient has submitted a complete Financial Assistance Application as outlined in this policy and the annual family income, adjusted for family size, is between 301% and 400% the FPL <u>AND</u> the patient has incurred total medical expenses at Providence hospitals in the prior 12 months in excess of 20% of their annual family income, adjusted for family size, for Eligible Services,</p>	<p>The patient is eligible for a one-time approval for Catastrophic Medical Expenses financial assistance 100% write-off on patient responsibility amounts for Eligible Services owed as of the date the Financial Assistance Application was submitted.</p>
<p>Pre-billing screening. If analysis by an industry-recognized financial assessment tool estimates an approximate household income, adjusted for family size, that falls within one of the ranges of the current FPL guidelines as shown on the right,</p>	<p>The patient is presumptively eligible for financial assistance write off on patient responsibility amounts for Eligible Services as follows:</p> <p>At or below 200% FPL is eligible for 100% presumptive write off 201% and 300% FPL is eligible for 75% presumptive write off 301% and 350% FPL is eligible for 50% presumptive write off 351% and 400% FPL is eligible for 25% presumptive write off</p>
<p>Pre collections screening. If a patient has not submitted a complete Financial Assistance Application as outlined in this policy but analysis by an industry-recognized financial assessment tool estimates an approximate household income, adjusted for family size, is at or below 300% of the current FPL guidelines,</p>	<p>The patient is presumptively eligible for financial assistance 100% write off on patient responsibility amounts for Eligible Services.</p>