#### Policy:

Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics provides medically necessary care regardless of ability to pay or insurance coverage status. Kootenai Health believes that medically necessary health care services should be accessible to all, regardless of age, gender, geographic location, cultural background, physical mobility or ability to pay. Kootenai Health is committed to excellence in providing high quality health care services, while serving the diverse needs of those living within its service area.

This policy describes the Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics Financial Assistance eligibility requirements and approval process. Generally, eligibility for Financial Assistance is determined by comparing the patient’s household income to the current year Federal Poverty Level Income Guidelines (FPG) as established by the Department of Health and Human Services, and eligible living and medical expenses to qualifying criteria.

#### Purpose:

The purpose of this policy is to establish and describe Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics Financial Assistance Policy and eligibility requirements, which are designed to promote access to medically necessary care for those without the ability to pay, and to offer a discount from billed charges for individuals who are able to pay for only a portion of the costs of their care.

These programs apply solely to emergency and other medically necessary healthcare services provided *at Kootenai Health locations,* and when there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting the service.

#### Definitions:

**Kootenai Health -** includes all entities, hospital, clinics, and other care facilities that currently bill under the Kootenai Health Tax ID number and and St. Mary’s Clearwater Valley Hospital and Clinics.

Financial Assistance – For the purposes of this policy, “financial assistance” includes charity care and other financial assistance programs offered by Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics for appropriate services for which Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics does not expect to be reimbursed due to a patient’s inability to pay, and ineligibility to qualify for government or other available financial assistance programs.

**Bad Debt –** Accounts are considered bad debt when the patient has demonstrated an unwillingness to pay his/her portion of the Kootenai Health or St. Mary’s Clearwater Valley Hospital and Clinics hospital or professional services bill(s), and has not provided documentation required to support the Financial Assistance application process. This applies to uncollectable billed amounts, excluding contractual adjustments, arising from failure to pay by patients or guarantors whose care has not been classified as Financial Assistance eligible.

**Discretionary Expenses –** A discretionary expense is a patient’s or guarantor’s cost that is not determined to be essential for the operation of the household. This includes expenses that can be reduced or eliminated without having an immediate impact on the patient.

**Eligible living and medical expenses –** Patient or guarantor expenses not classified as discretionary.

**Eligibility –** a determination made by Kootenai Health or St. Mary’s Clearwater Valley Hospital and Clinics based upon required financial documentation to verify the patient’s inability to pay for medically necessary services provided to that patient.

#### Federal Poverty Guidelines – (defined through Federal DHS, updated annually on the KH and CVH/SMH website, following government published updates.)

**Catastrophic Care –** a circumstance of extraordinary medical expense from which a patient or guarantor would not have the ability to pay off the bill in their lifetime, given the patient or guarantor’s validated income and available resources, without it resulting in a severe financial hardship.

**Presumptive Eligibility –** Established and defined criteria through which Kootenai Health or St. Mary’s Clearwater Valley Hospital and Clinics may determine a patient’s eligibility for Financial Assistance in the absence of supporting documentation. In this event, Kootenai Health or St. Mary’s Clearwater Valley Hospital and Clinics may use outside agency information to complete the eligibility determination and level of financial assistance awarded.

Examples:

* Homelessness or Transient
* Deceased with no Estate
* Severe mental illness
* Social/Family abandonment

**Family –** A group of two or more persons related by *birth, marriage, or adoption,* who live together; all such related persons are considered as members of one family. This may include individuals residing together who have consented to an arrangement similar to ties of blood or marriage. An unmarried person living alone will be considered a family for purposes of this policy.

**Income** – Personal Income: Total cash receipts and gross wages before taxes, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, or alimony, and investment activities paid to the individual and/or family members. Business Income, EBIDA: Profit or Loss (from Line 29, Schedule C), excluding Depreciation, Interest, and Amortization. Requires detail from Line 48, to have ‘Other Expenses’ considered.

**Assets** – Any item of economic value owned by an individual or corporation, especially that which could be converted to cash. Examples include: checking and savings accounts, securities, real estate, car, boat, life insurance, IRA, trust accounts, and other property.

**Indigent Persons** – Patients who have exhausted any third-party sources, including Medicare, Medicaid and County, and whose income is equal to or *below 200%* of the federal poverty standards adjusted for family size, or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third party payer.

**Uninsured** – No third party insurance coverage. Health savings accounts, for the purpose of this policy, are considered insurance. Depending on other available resources, an uninsured patient is not necessarily assumed to also be indigent or otherwise eligible for financial assistance.

#### Eligibility requirements:

Information regarding eligibility and the Financial Assistance application process is available and can be obtained at all points of patient registration at Kootenai Health Hospital and clinic locations and St. Mary’s Clearwater Valley Hospital and Clinics, from Financial Counselors, Customer Service, and Social Services Departments, and is located through the Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics website.

1. A Financial Assistance request should be initiated by the patient, guarantor, or appropriate agent representing the patient. Patients demonstrating and/or communicating a need for assistance will be evaluated according to this policy.
2. Patients who may be eligible for Financial Assistance shall be identified as early as possible in the patient care cycle. However, determination of eligibility can take place after discharge at any point in the billing cycle.
3. After a request has been initiated, the patient will be screened by a Financial Counselor. This screening process will give the patient a preliminary determination if sufficient eligibility is indicated to allow the application process to move forward.
   1. If preliminary eligibility is indicated, the patient will receive a Financial Assistance application

The Financial Counselor will instruct the patient or responsible party that the application must be completed, signed and submitted to an authorized Kootenai Health or St. Mary’s Clearwater Valley Hospital and Clinics representative within 21 days of the screening date, or such time that is medically and reasonably feasible to submit the required documentation. Collection efforts will not be initiated during the financial assistance determination process provided the responsible party is cooperative with the hospital’s efforts to reach an initial determination of sponsorship status.

1. In order to be evaluated for Financial Assistance, it is the responsibility of the patient/guarantor to submit verification of annual income and assets through the completion and timely submission of a Financial Assistance Application.
   1. During the screening and application process, the patient’s account(s) will maintain a “Self Pay” status, which will allow the billing and collection process to continue. This billing classification will not change until a final approval decision has been recorded.

#### Determination of Eligibility:

A valid completed Financial Assistance Application will include the following documented information:

* 1. Current, valid Picture I.D.
  2. Proof of income, to include:
     1. The patient’s most recent filed Federal Tax Return (if tax return covers a prior calendar year, then a current W-2 form for all household/family members will also be required).
     2. Current three months of employer pay stubs
     3. Copies of all checking, savings and other bank statements for last three months
     4. Social security benefits
     5. Disability and/or Unemployment benefits received
     6. Current food stamps award letter from patient’s state of residence
     7. Written documentation from other income sources.
     8. A copy of a most recent application denial from County program or Medicaid
  3. Proof of income excludes non-cash benefits (such as housing subsidies), capital gains or losses, and household income from non-family persons. However, non-family persons, such as roommates, may be considered if expenses are shared.
  4. Proof of Assets, to include supporting documentation of:
     1. Value of home (if owned)
     2. Vehicles
     3. Land
     4. Stocks and bonds
     5. Life insurance with cash value
     6. Assets available through a family or other Trust
  5. If unable to provide the tax return, two alternate documents may be substituted: Supporting W-2 or 1099 statements, most recent bank and broker statements listed in the federal tax return, and current credit report.
  6. In the event that the responsible party is not able to provide any of the documentation described above, Kootenai Health may rely upon written and signed statements from the responsible party in the verification process. This circumstance should be a rare occurrence, with a final determination of financial assistance eligibility or classification as “indigent” authorized by both the Financial Counseling Manager and the Director of Revenue Cycle.
     1. Based on the information provided and the verification process, after review of the Application, the Revenue Cycle Director, or designee, may waive documentation requirements, when it is apparent that the patient or responsible party clearly meets the Financial Assistance guidelines.

1. Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics will complete the review and approval process within seven business days from receipt of the completed application, at which time a decision letter will be mailed to the patient or responsible party.
2. Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics will approve Financial Assistance only after all other means of financial support are exhausted from available payment sources, including but not limited to Medicaid and Idaho’s County Programs.
3. Once the patient meets eligibility requirements, any outstanding balances from prior services that are owed by the patient as of the date of application, for deductible, coinsurance or where the insurance benefits have been exhausted, and which have not previously been assigned to bad debt, may qualify for Financial Assistance. In such cases, the determination of the benefit will be based upon the patient balance due at time of application, and not the original billed amount.
4. Financial Assistance eligibility and discount determination is based on the patient’s medical expenses, financial status at the time of application, and may also be impacted by the household’s discretionary expense. (See “Determination of Eligibility”, below.) In certain circumstances, in the absence of qualifying documentation, the patient may meet presumptive eligibility criteria.
5. Patients eligible for Financial Assistance will be informed in writing of the determination (approval, partial approval, or denial) within 14 days of Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics receiving a completed and signed application. For patients awarded less than 100% Financial Assistance, this notification letter will include instructions to contact the Financial Counselor to arrange payment (which may include terms of a payment plan) of outstanding amounts due.
6. Patients whose application has been denied will be sent a letter explaining the reason for the denial and a contact number should they wish to discuss the application further.
7. Patients whose application has been denied has an option to appeal the decision. The Financial Counseling Manager, or designee, will make final determination on appealed decisions.
8. Approval of Financial Assistance is granted on basis of all current hospital or professional services accounts and/or outstanding balances included for consideration in the application process.
9. Financial Assistance applications may be considered for up to six (6) months forward from current service date(s) covered through the application process, unless the patient or guarantor’s ability to pay has changed during the eligible time period. Should future care, within the six month application period, be considered for eligibility, it is the patient’s responsibility to inform Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics of any change in financial status, and it is the Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics representative’s responsibility to validate the information provided.

#### Pending Medicaid or County - Effect on Financial Assistance Eligibility

The pending Medicaid or County and Financial Assistance application processes are not concurrent events. Determination of Medicaid and/or County benefit must be finalized prior to evaluating an application for Financial Assistance. If a Financial Assistance application is completed, it will pend until a decision from the County or State Medicaid agency is returned. Otherwise, it is the patient’s responsibility to contact Kootenai Health or St. Mary’s Clearwater Valley Hospital and Clinics Financial Counseling after receiving a State or County denial, should the patient wish to pursue Financial Assistance.

LEVELS OF FINANCIAL ASSISTANCE

For individual accounts with patient responsibility below $50.00, Financial Assistance does not apply**.**

|  |  |
| --- | --- |
| **Level of Financial Assistance** | **Qualifying Federal Poverty Level** |
| 100% Assistance Award | 0-175% of FPL |
| 50% Assistance Award | 176-200% of FPL |
| 30% Assistance Award | 201-250% of FPL |

#### Special Circumstances and Presumptive Eligibility

A patient who is unable to provide documentation or who is unable to follow the application procedures may receive full or partial financial assistance, with the approval of the Chief Financial Officer or Director of Revenue Cycle Operations. The Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics authorized representative must document the decision, including the reasons why the patient did not meet criteria outlined in the policy. Circumstances may include, but are not limited to, deceased with no estate, homeless, transient, severe mental illness, and social/family abandonment.

#### Out of State Medicaid – No Provider Number

Patients who are actively enrolled in a non-participating Out of State Medicaid program (for which Kootenai Health or St. Mary’s Clearwater Valley Hospital and Clinics is not enrolled), where a provider number is not available, and whose prorated charges are less than twenty-five hundred dollars ($2,500), may also satisfy the Special Circumstances or Presumptive Eligibility criteria. In such cases, the patient must provide documented proof of current Medicaid eligibility in their state of residence. For these patients, the Out of State Medicaid plan will be replaced with the Financial Assistance classification. Such accounts will be initially flagged through Registration or Patient Access department, and will be sent to the Financial Counseling Manager for review and approval.

#### Catastrophic Financial Assistance

If a patient meets the conditions through which catastrophic financial assistance may apply, the financial counselor will submit the application for consideration to the department manager or to the Director of Revenue Cycle Operations for final determination. The patient will be notified of approval or denial, within seven business days, as per policy.

#### Non-Medically Necessary Care:

* Financial Assistance is not applicable to non-emergent services, such as elective services or procedures which do not meet criteria for medical necessity, as determined by a physician or care manager.
* Financial Assistance will not be granted for services not covered by Medicaid per the patient’s state-specific guidelines of medically necessary care. Such non-covered, non-emergent services will be identified through the pre- authorization process, and may result in a delayed decision. The referring physician’s office staff, the financial counselor or the Financial Clearance Specialist will notify the patient if there is a possibility that services may be deemed non-medically necessary.
* Financial Assistance will not be granted for Medicaid accounts where Emergency room visits or Rehab/Therapy services have exceeded the maximum allowable visits for the patient.

#### Patient Cooperation Standards

A patient must exhaust all other possible payment options, including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third-parties, prior to being considered for any level of Kootenai Health or St. Mary’s Clearwater Valley Hospital and Clinics Financial Assistance. Failure on the part of the responsible party to cooperate with Kootenai Health in the eligibility process shall be grounds for denial of any benefit covered by this policy.

#### Continuing Eligibility

For a patient to remain eligible for Kootenai Health or St. Mary’s Clearwater Valley Hospital and Clinics Financial Assistance, the patient/guarantor must apply for and continue to pursue all other benefits for which they are entitled, or may become entitled, including Medicare, Medicaid, Social Security Disability, or any other state or federal programs. This responsibility continues until the patient or guarantor receives documented approval or denial from the applicable benefit program. If the patient is denied benefits due to lack of cooperation, Kootenai Health or St. Mary’s Clearwater Valley Hospital and Clinics Financial Assistance may not be granted or may be revoked, and any benefits may be subject to review and may be reversed. Should this occur, any current or outstanding balances may revert back to the financial responsibility of the patient or guarantor.

The patient or responsible party is required to reapply for Financial Assistance, should any change in the patient’s household size, status, or income level occur. This requirement is applicable at any time following the original decision.

#### Approval authority for Financial Assistance

* The department manager may approve up to $25,000, based on the application meeting policy criteria.
* Director of Revenue Cycle Operations may approve financial assistance up to $50,000, based on Financial Counseling recommendation and the application meeting policy criteria.
* Amounts greater than $50,000 require approval from the Chief Financial Officer.
* Catastrophic financial assistance or other extenuating circumstance decisions, requires approval from either the Director of Revenue Cycle Operations or the Chief Financial Officer.

All personal and financial documentation submitted by the patient or guarantor to support the Financial Assistance application process, will be maintained as part of the patient’s confidential record and protected in accordance with the Health Information Portability and Accountability Act (HIPAA) and the Kootenai Health and St. Mary’s Clearwater Valley Hospital and Clinics retention policy.

#### Addendum A

Date Financial Counselor Received

\_

**Financial Assistance Application**

Kootenai Health, Kootenai Clinics, Kootenai Heart Clinics Northwestm Kootenai Imaging and St. Mary’s Clearwater Valley Hospital and Clinics

We understand that unexpected medical debt can be a financial hardship and we are committed to assist you with your financial obligation. **This application needs to be completed within 21 days** **and returned to one of the following locations:**

**Mailed to: OR Mailed to:**

Clearwater Valley Hospital/Clinics St. Mary’s Hospital/Clinics

301 Cedar PO Box 137

Orofino, ID 83544 701Lewiston St.

Cottonwood, ID 83522

**OR** you can drop it off at either hospital or clinics.

In order to process your application, the following information (if applicable) is required:

## Do not send originals

* + Current, valid Picture I.D.
  + The patient’s most recent filed Federal Tax Return (if tax return covers a prior calendar year, then a current W-2 form for all household/family members will also be required).
  + Current three months of employer pay stubs
  + Copies of all checking, savings and other bank statements for last three months
  + Social security benefits
  + Disability and/or Unemployment benefits received
  + Current food stamps award letter from patient’s state of residence
  + Written documentation from other income sources.
  + A copy of a most recent application denial from County program or Medicaid
  + Proof of Assets, to include supporting documentation of:
    - Value of home (if owned)
    - Vehicles
    - Land
    - Stocks and bonds
    - Life insurance with cash value
    - Assets available through a family or other Trust

Please contact Financial Services Counseling at 208-476-4555 or 208-962-3251 if you have any questions. CVHC Fax 208-476-5385, SMH Fax 208-962-2478.

*\*We use the Federal Poverty Guidelines when determining eligibility*

**Medical bills you wish to be considered for assistance:**

**Provider Name** **Date of Service** **Account Number** **Amount Owed**

**Comments**

Revised: 5/1

## Patient/Applicant

First Name Middle Last Name Date of Birth

Address City State Zip

Spouse/Significant Other # of Dependents in Home Age of Dependents

Daytime Phone Message Phone Work Phone

Is Patient a minor? Yes No Parent/Guarantor

**LIVING ARRANGEMENT**: Rent Own Other (explain)

## Gross Monthly Income

Self Spouse/Significant Other Unemployment Food Stamps Social Security / SSI/ SSD Loans / Gifts Worker’s Comp Inheritance / Trust Veteran’s Benefits Child Support Pension / Retirement Other

## TOTAL Gross Income $

**Monthly Expenses**

Rent/Mortgage

2nd Mortgage

Space Rent

Food

Electricity/Heat

Gasoline / Fuel Prescriptions Life Insurance Child Care Doctor / Hospital

Auto Insurance Car Payment Home / Rent Ins. Garnishments Fines

Water/Sewer/Trash

Child Support

Other Expenses

Telephone Health / Accident Ins.

## TOTAL Monthly Expenses $

**ASSETS**

*All Business & Personal Bank Accounts:*

Checking Account - Bank Name Current Balance Checking Account - Bank Name Current Balance Savings Account – Bank Name Current Balance Savings Account – Bank Name Current Balance Stocks, CD’s, Trusts Current Balance 4O1K, Retirement, IRAs Current Balance Life Insurance Cash Value Other Assets Value

Home/ Properties

Value Purchase Date Amount Owed

Land / Rental Properties

Value Purchase Date Amount Owed

Vehicle

Year Make Current Value Amount Owed Monthly Payment

Vehicle

Year Make Current Value Amount Owed Monthly Payment

Vehicle

Year Make Current Value Amount Owed Monthly Payment

Recreational (Boat, RV, ATV, MC)

Year Type Current Value Amount Owed Payment

Recreational (Boat, RV, ATV, MC)

Year Type Current Value Amount Owed Payment

I authorize St. Mary’s Clearwater Valley Hospital and Clinics to verify the information that I have supplied on this statement to be true and to access credit information if needed.

Signature Date

Revised: 04/2020

**Addendum B:**

# 2020 Annual Poverty Guidelines are in a separate attachment.

### 2018 Annual Poverty Guidelines

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family Size** | **100%** | **150%** | **175%** | **200%** | **225%** | **250%** |
| 1 | 12,140.00 | 18,210.00 | 21,245.00 | 24,280.00 | 27,315.00 | 30,350.00 |
| 2 | 16,460.00 | 24,690.00 | 28,805.00 | 32,920.00 | 37,035.00 | 41,150.00 |
| 3 | 20,780.00 | 31,170.00 | 36,365.00 | 41,560.00 | 46,755.00 | 51,950.00 |
| 4 | 25,100.00 | 37,650.00 | 43,925.00 | 50,200.00 | 56,475.00 | 62,750.00 |
| 5 | 29,420.00 | 44,130.00 | 51,485.00 | 58,840.00 | 66,195.00 | 73,550.00 |
| 6 | 33,740.00 | 50,610.00 | 59,045.00 | 67,480.00 | 75,915.00 | 84,350.00 |
| 7 | 38,060.00 | 57,090.00 | 66,605.00 | 76,120.00 | 85,635.00 | 95,150.00 |
| 8 | 42,380.00 | 63,570.00 | 74,165.00 | 84,760.00 | 95,355.00 | 105,950.00 |

For family units of more than 8 members, add $4,320.00 for each member.

### 2018 Monthly Poverty Guidelines

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family Size** | **100%** | **150%** | **175%** | **200%** | **225%** | **250%** |
| 1 | 1,011.67 | 1,517.50 | 1,770.42 | 2,023.33 | 2,276.25 | 2,529.17 |
| 2 | 1,371.67 | 2,057.50 | 2,400.42 | 2,743.33 | 3,086.25 | 3,429.17 |
| 3 | 1,731.67 | 2,597.50 | 3,030.42 | 3,463.33 | 3,896.25 | 4,329.17 |
| 4 | 2,091.67 | 3,137.50 | 3,660.42 | 4,183.33 | 4,706.25 | 5,229.17 |
| 5 | 2,451.67 | 3,677.50 | 4,290.42 | 4,903.33 | 5,516.25 | 6,129.17 |
| 6 | 2,811.67 | 4,217.50 | 4,920.42 | 5,623.33 | 6,326.25 | 7,029.17 |
| 7 | 3,171.67 | 4,757.50 | 5,550.42 | 6,343.33 | 7,136.25 | 7,929.17 |
| 8 | 3,531.67 | 5,297.50 | 6,180.42 | 7,063.33 | 7,946.25 | 8,829.17 |

If gross income falls in this range pt may receive charity at 100% If gross income falls in this range pt may receive charity at 50% If gross income falls in this range pt may receive charity at 30%

If gross income falls in this range pt may be over income for charity

**https://aspe.hhs.gov/poverty-guidelines** As of 1/13/2018

**Addendum C:**

# Approval Letter (100%, 50%, 30%)

RE: Request for Financial Assistance

This letter is to inform you St. Mary’s Clearwater Valley Hospital and Clinics has approved your request for uncompensated care.

You are approved for a % adjustment on the self-pay balance of your St. Mary’s Clearwater Valley Hospital and Clinics accounts. If you have balances due with an outside agency (such as labs, ambulance or anesthesia), they may write off a portion of your balance from their billing. To request this, please present a copy of this letter to their office.



o

Please contact financial counseling at CVH 208-476-4555 or SMH, 208-962-3251 to make payment arrangements on the remaining balance on your accounts.

 You are approved for a 100% adjustment on the self-pay balance of your St. Mary’s Clearwater Valley Hospital and Clinics accounts. If you have balances due with an outside agency (such as labs, ambulance or anesthesia), they may write off a portion of your balance from their billing. To request this, please present a copy of this letter to their office.

**Addendum D:**

# Denial Letter – (Missing Documentation, Over Poverty Guidelines)

RE: Request for Financial Assistance

 This letter is to inform you that St. Mary’s Clearwater Valley Hospital and Clinics has denied your request for uncompensated care. The results of your application determine that you exceed the Annual Poverty Guidelines for income/asset requirements.

 St. Mary’s Clearwater Valley Hospital and Clinics has denied your request for uncompensated care due to you not providing the required documentation by your submission deadline.

 St. Mary’s Clearwater Valley Hospital and Clinics is requesting additional documentation to process your financial assistance application. CVH 301 Cedar, Orofino ID 83544 or SMH PO Box 137, Cottonwood, ID 83522 by \_\_\_.

* Copy of most recent filed Federal Tax Return **OR** two alternative substitutes, to include a current W-2 or 1099, your most recent bank statement, a broker’s statement from the IRS, and current credit report.
* Current three months of employer pay stubs
* All pages of all checking, savings and other bank statements for the last 3 month
* Current food stamp award letter from patient’s current state of residence
* Social security benefit documentation
* Disability and/or unemployment benefits documentation
* Written documentation from any other income sources, to include assistance received from an individual or organization
* Proof of mortgage, rent and utilities payment
* Proof of assets, to include supporting documentation of:
  + Value of home (if owned)
  + Vehicles
  + Stocks and bonds
  + Life insurance with cash value
  + Assets available through a family or other Trust
* Current, Valid Picture ID

Please contact our business office at CVH, 208-476-4555 or at SMH 208-962- 3251 to make payment arrangements on the remaining balance on your accounts.

**Compliance Criteria**

#### List Departments affected by this document and which Committees approved this document (including your own service line committee).

|  |  |  |
| --- | --- | --- |
| **Departments Affected** | **Approved by:** | **Date Approved** |
| Financial Counseling | Wendy Bird, Manager Financial Counseling and Cash Fund Posting | 1/3/19 |
| Patient Access | John Earley, Manager Patient  Access and Financial Clearance | 1/2/19 |

meetings

**How will this document be disseminated to affected staff?**

* Reformatted with New Template
* New Document
* Replacement of existing document

If a replacement, title of document being replaced:

☒ Revision

* If an organizational document exists, explain why this document is still necessary:
* Archive Specify reason for archival

Director Revenue Cycle Operations

#### Document Owner Title