



## Oregon Health Authority Guidance on Financial Assistance Communications

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### General information

This document outlines the Oregon Health Authority's (OHA) recommended language for hospital notifications related to hospital financial assistance in accordance with HB 3320 (2023) codified as ORS 442.615.

All hospital communications must comply with Oregon Administrative Rules 409-023-0120-0125. Notifications must be delivered by letter, email, message or notification on an online patient portal (if the patient is a registered user), a distinct notice on the billing statement, an insert accompanying a billing statement, or an in-person acknowledgement signed by the patient.

In addition, the communication must be written in plain language. To be plain language, a communication should substantially align to the following:

1. Uses short sentences and paragraphs.
2. Uses everyday commonly understood words.
3. Uses simple and active verb forms.
4. Uses readable fonts at least 12 points in size.
5. Written and organized in a clear and coherent manner.
6. Is designed to facilitate ease of reading and comprehension.

All notifications should contain four pieces of information:

1. What the notice is for (to share the results of the prescreening or financial assistance application).
2. The results of the prescreening or financial assistance application and impact on the patient's bill.
3. How the patient may apply for financial assistance, ask for an appeal, or get more information if needed.
4. The department or individual the patient may contact, as well as direct contact information (email addresses and phone numbers), for further questions. Do not include generic email addresses or phone numbers.

OHA recommends that hospitals use bold font or underline font to draw attention to the most important details of the notice. Do not use italics to draw attention; italicized words may be hard for some people to read.

The notice should include any relevant web links, email addresses or other means by which a patient may find more information or access a financial assistance application.

## Recommended language for presumptive eligibility screenings

### Presumptive eligibility determination indicates patient is 200% or below FPL

#### Notice of screening for financial assistance.

This notice is to inform you that [Insert hospital name] screened you for financial assistance. This is a screening that [Insert hospital name] must perform based on state law ORS 442.615.

Our screening has found that you are **eligible for full financial assistance**. This means you do **not owe any money** for the portion of the bill you are responsible for after insurance, if any, has been billed. [Insert hospital name] will automatically adjust your bill.

If you have any questions related to this notice or would like more information, please contact [Insert direct contact information, including phone and email].

### Presumptive eligibility determination indicates patient is greater than 200% FPL

#### Notice of screening for financial assistance.

This notice is to inform you that [Insert hospital name] screened you for financial assistance. This is a screening that [Insert hospital name] must perform based on state law ORS 442.615.

Our screening has found that you are eligible **for partial financial assistance of [insert percent reduction of bill – 25%, 50%, or 75%]** of the amount you are responsible for. This means the amount you owe will be **reduced by [Insert percentage]** after your insurance, if any, has been billed. [Insert hospital name] will automatically adjust your bill.

You are entitled to apply for, and may be eligible to receive, more financial assistance. For more information and questions related to this notice please contact:

[insert direct phone number and email to department that works with financial assistance applications],[insert link to financial assistance application webpage],[insert in-person location directions to department that works with financial assistance applications in the hospital]

Patients are eligible to apply for financial assistance up to 240 days (about eight months) after the first billing statement, or at least 12 months after making a payment for services, [or any greater time period specified in hospital financial assistance policy].

### Presumptive eligibility determination indicates patient is not eligible for financial assistance.

#### Notice of screening for financial assistance.

This notice is to inform you that [Insert hospital name] screened you for financial assistance. This is a screening that [Insert hospital name] must perform based on state law ORS 442.615.

Our screening has found that you are **not eligible for financial assistance**. [Insert hospital name] will not make any changes to your bill at this time.

**You are still entitled to apply for, and may be eligible to receive, financial assistance.** For more information and questions related to this notice please contact:

[insert direct phone number and email to department that works with financial assistance applications], [insert link to financial assistance application webpage],  
[insert in-person location directions to department that works with financial assistance applications in the hospital]

Patients are eligible to apply for financial assistance up to 240 days (about eight months) after the first billing statement, or at least 12 months after making a payment for services, [or any greater time period specified in hospital financial assistance policy].

### **Unable to determine presumptive eligibility status.**

#### Notice of screening for financial assistance.

This notice is to inform you that [Insert hospital name] screened you for financial assistance. This is a screening that [Insert hospital name] must perform based on state law ORS 442.615.

Our screening was **unable to determine if you are eligible for financial assistance**. [Insert hospital name] will not make any changes to your bill at this time.

**You are still entitled to apply for, and may be eligible to receive, financial assistance.** For more information and questions related to this notice please contact:

[insert phone number to department that works with financial assistance applications],  
[insert link to financial assistance application webpage],  
[insert in-person location directions to department that works with financial assistance applications in the hospital]

Patients are eligible to apply for financial assistance after receiving care for at least 240 days following the first billing statement or at least 12 months after making a payment for services, [any additional time period specified in hospital financial assistance policy].

### **Recommended language for notification of financial assistance application results and notice of ability to appeal.**

Note: Notifications must be delivered by letter, email, message or notification on an online patient portal (if the patient is a registered user), a distinct notice on the billing statement, an insert accompanying a billing statement, or an in-person acknowledgement signed by the patient. They must be written in plain language. **Notifications must be delivered separately and in addition to any information related to financial assistance included on billing statements.**

## Complete applications resulting in full financial assistance.

### Notice of results of financial assistance application submission.

[Insert Hospital name] has reviewed your application for financial assistance. We have determined that you are eligible for **full financial assistance**.

This means you will **not owe any money** for the portion of the bill you would be responsible for after your insurance, if any, has been billed. [Insert hospital name] will automatically adjust your bill.

You will remain eligible for financial assistance for nine months, until [insert date]. During this time, you will not be required to complete another financial assistance application.

If you have questions about this notice, please contact: [Insert direct contact information].

## Complete applications resulting in partial financial assistance.

### Notice of results of financial assistance application submission.

[Insert Hospital name] has reviewed your application for financial assistance. The application is complete, and we have determined that **you are eligible for a partial financial assistance adjustment** of [insert percent].

[Insert Hospital Name] will reduce your bill by [percentage] after your insurance (if any) has been applied. Your billing statement will reflect this change.

You will remain eligible for financial assistance for nine months, until [insert date]. During this time, you will not be required to complete another financial assistance application.

This decision is based on the hospital's determination of your household size and income. You may request to receive the information we used to determine your household size and income by [insert instructions and specific information for responsible department or individual].

If you disagree with [insert hospital's name]'s financial assistance determination, **you may appeal this decision**.

You may appeal by any of these methods:

- You may submit a written appeal by letter, email, or in-person delivery. You may direct written appeals to [insert direct email addresses, mail addresses or delivery locations].
- You may request a review of your application and appeal by [insert name and title of CFO or the designee of the CFO]. [insert specific contact information and instructions].
- [Any additional hospital specific process developed]

**You have at least 45 days from the date of this notification to appeal**, although there may be additional time available to you. Please contact [hospital name] to find out specific information.

[list specific contact information for responsible party or individual].

### **Incomplete financial assistance applications.**

#### Notice of results of financial assistance application submission.

[Insert Hospital name] has reviewed your application for financial assistance. **Your application is missing information and requires further action to process.**

To complete your application, you must do the following:

[Insert specific action required. Examples: provide missing information on the application, provide proof of household income, provide requested documents, etc.]  
[Provide the means to submit the corrections]

For any question or assistance in completing your financial assistance application, contact us at [insert specific person or department and direct contact information].

### **Financial assistance application resulting in denial of financial assistance.**

#### Notice of results of financial assistance application submission.

[Insert Hospital name] has reviewed your application for financial assistance. We have determined you are **not eligible for financial assistance.**

This decision is based on the hospital's determination of your household size and income. You may request to see the information we used to determine your household size and income level by [insert instructions and specific information for responsible department or individual].

If you disagree with [insert hospital's name]'s financial assistance determination, **you may appeal this decision.**

You may appeal by any of these methods:

- You may submit a written appeal by letter, email, or in-person delivery. You may direct written appeals to [insert direct email addresses, mail addresses or delivery locations].
- You may request a review of your application and appeal by [insert name and title of CFO or the designee of the CFO]. [insert specific contact information and instructions].
- [Any additional hospital specific process developed]

**You have at least 45 days from the date of this notification to appeal,** although there may be additional time available to you. Please contact [hospital name] to find out specific information.

[list specific contact information for responsible party or individual].