Purpose

Intermountain Health is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for Medically Necessary care based on their household situation.

Intermountain Health will provide, without discrimination, care of emergency medical conditions to individuals regardless of their ability to pay or their eligibility for financial assistance or for government assistance.

Financial assistance shall be provided to patients who meet program qualifications and reside within one of Intermountain Health's service areas. Financial assistance shall be provided, without discrimination, to patients from outside the Intermountain Health services areas, who otherwise qualify for the program, and who present with an urgent, emergent, or life-threatening condition.

Intermountain Health will use the most current Federal Poverty Guidelines to determine eligibility under its financial assistance policy. Patients qualifying for financial assistance may receive fully discounted care or pay a discounted fee under this policy. A medical hardship provision extends financial assistance to patients with incomes above the financial assistance eligibility threshold and medical bills that exceed a threshold percentage of the patient's household income.

Financial Assistance is provided to patients, or a patient's Guarantor, in compliance with federal, state and local laws. Financial assistance is extended with the requirement that patients will cooperate with Intermountain Health procedures for applying for such financial assistance or other forms of payment. They will also contribute to the cost of their care according to their ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health. Access to insurance or Medicaid coverage has extended significantly through the federal and state Health Exchanges. It is expected that any uninsured patient cooperate with Intermountain Health in determining the availability of Medicaid or insurance coverage.

Financial Assistance shall be based on financial need and shall not consider race, ethnicity, religion, creed, gender, age, social or immigration status, sexual orientation, or insurance status.

Accordingly, this written policy:

- Includes eligibility criteria for financial assistance – fully or discounted care.
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy.
- Describes the method by which patients may apply for financial assistance.
- Describes the methods to be used to widely publicize the policy within the communities served by Intermountain Health
- Limits the amounts that Intermountain Health will charge for emergency or other Medically Necessary care provided to individuals eligible for financial assistance. The limit will be based upon the average rate generally approved of by Medicare.

Scope: This policy applies to all persons working for or on behalf of Intermountain Health. This policy applies to all Intermountain Health hospital facilities, clinics, and employed physicians including but not limited to:

Colorado

Good Samaritan Hospital, Lutheran Hospital, Platte Valley Hospital, Saint Joseph Hospital, and St. Mary's Regional Hospital

Idaho

Cassia Regional Hospital

Montana

Holy Rosary Hospital, St. James Hospital, and St. Vincent Regional Hospital

Utah

Alta View Hospital, American Fork Hospital, Bear River Valley Hospital, St George Regional Hospital, Fillmore Community Hospital, LDS Hospital, Layton Hospital, Logan Regional Hospital, McKay-Dee Hospital Center, Orem Community Hospital, Primary Childrens Hospital, Riverton Hospital, Sanpete Valley Hospital, Spanish Fork Hospital, Sevier Valley Hospital, Park City Hospital, Utah Valley Hospital, Cedar City Hospital, Heber Valley Hospital, Intermountain Medical Center, and The Orthopedic Specialty Hospital

In order to manage its resources responsibility and to allow Intermountain Health to provide the appropriate level of assistance to persons in need, the Intermountain Board of Directors establishes the following financial assistance guidelines.

Definitions:

For the purpose of this policy, the following items are defined:

Amounts Generally Billed (AGB) – The amounts generally billed for emergency or other Medically Necessary care to individuals who have insurance covering such care. AGB is calculated using the "Look Back Method" in accordance with the §1.501(r)-5(b). (AGB excludes Medical Group and Homecare)

Deceased – the person who has died, as used in the handling of his/her estate, probate of will and other proceedings after death.

Discounted Care – Financial Assistance that provides care at a discounted fee to eligible patients with annualized family incomes between amounts equal to or greater than 250% but less than or equal to 500% of the Federal Poverty Guidelines. This type of Financial Assistance waives the patient financial obligation, with the exception of amounts that may be due after applicable discounts have been applied for medical services provided by Intermountain Healthcare.

Federal Poverty Guidelines – Federal Poverty Guidelines are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current guidelines are located in the Primary Sources section below. Intermountain Healthcare updates its federal poverty table annually on April 1st.

Federal Poverty Level (FPL) – guidelines that are updated and published annually by the U.S. Department of Health and Human Services that define financial eligibility for certain federal programs and benefits.

Financial Assistance – assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for Medically Necessary services provided by Intermountain Health and who meet the eligibility criteria for such assistance.

Financial Counselors – caregivers who help patients and/or Guarantors make good financial decisions by answering questions regarding the cost of healthcare services, setting up payment plans, or identifying other forms of Financial Assistance.

Fully Discounted Care – a 100% waiver of patient financial obligation resulting from medical services provided by Intermountain Health. Uninsured and Underinsured Patients with annualized family household incomes not in excess of 250% of the Federal Poverty Guidelines will be eligible for fully Discounted Care.

Gross Charges – the total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Guarantor – an individual other than the patient who is responsible for payment of the patient's bill.

Homeless – an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation.

Medical Hardship – Financial Assistance that provides a discount based on a sliding scale, to eligible patients with annualized family household income in excess of 500% of the Federal Poverty Guidelines and financial obligations resulting from medical services provided by any Intermountain Health entity or provider that exceed 25% of annualized family income.

Medically Necessary – as defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

Surviving Spouse – individual who is the patient's spouse at the time of the patient's death.

Uninsured patient – an individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation, or other third-party assistance to assist with meeting his/her payment obligations.

Underinsured Patient – an individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by Intermountain Health.

Urgent and Emergent Care – the diagnosis and treatment of medical conditions which are serious and may pose an immediate threat to life and health.

Work Queue (WQ) – a workable list or interactive report.

Policy:

Eligible Services:

Services and goods eligible under this financial assistance policy include the following:

1. Trauma and emergency medical services provided in an emergency setting. Care will continue until the patient's condition has been stabilized prior to any determination of payment arrangements;
2. Services for a condition that, if not treated promptly, would lead to an adverse change in the health status of a patient;
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and/or
4. Other Medically Necessary services scheduled in advance and assessed and approved at the discretion of Intermountain Health.

   There are a number of providers involved in the delivery of patient care. A list of providers that are covered under this policy can be found on the public website, the attachment in the Secondary Materials section below, or by requesting a written copy. Providers not covered under this policy may have their own Financial Assistance policy and eligibility requirements. To inquire about their programs, patients should contact their provider directly.

Services not eligible for Financial Assistance include the following:

1. Elective procedures not Medically Necessary including, and not limited to, cosmetic services. A list of excluded services is available in the Secondary Materials section below.
2. Other care providers not billed through Intermountain Health (e.g., independent physician services, private-duty nursing, ambulance transport, etc.). Patients must contact the service providers directly to inquire about assistance and negotiate payment arrangements with these practices.

Eligibility and Assistance Criteria

Eligibility for financial assistance shall be considered for those individuals who are uninsured, underinsured, and unable to pay for their care, based upon a determination of financial need in accordance with this Policy. When determining patient eligibility, Intermountain Health does not take into account race, gender, age, sexual orientation, religious affiliation, social or immigrant status, or age of the patient's account.

Intermountain Health shall provide financial assistance to patients, or a patient's guarantor, in compliance with federal, state, and local laws. Financial assistance shall be based on financial need and shall not consider race, ethnicity, religion, creed, gender, age, social or immigration status, sexual orientation or insurance status.

Applicants for financial assistance are responsible for applying for public programs for available coverage. They are expected to pursue public or private health insurance coverage for care by Intermountain health. The patient's, or a patient's guarantor's, cooperation in applying for applicable programs and identifiable funding sources, including COBRA coverage (a federal law allowing for a time-limited extension of health care benefits) shall be required. If Intermountain Health determines that COBRA coverage is possible, and the patient is not Medicaid or Medicare beneficiary, the patient pr patient's guarantor, shall provide Intermountain Health with information necessary to determine the monthly COBRA premium. They will be expected to cooperate with Intermountain Health staff to determine whether they qualify for Intermountain Health COBRA premium assistance, which may be offered for a limited time to assist in securing insurance coverage.

Patients, or patient's guarantors, who do not cooperate in applying for programs they may pay for their health care services such as Medicaid, may be denied financial assistance. Intermountain Health shall make affirmative efforts to assist a patient or patient's guarantor, apply for public and private programs.

In accordance with FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTLA) regulations, no patient shall be screened for financial assistance or payment information prior to the rendering of services in emergency situations.

Fully Discounted (No Charge) Care: For eligible services, fully Discounted Care will be provided to a patient, or patient's Guarantor, meeting the following criteria:

1. Uninsured and Underinsured patients meeting other eligibility criteria and with annual family incomes not in excess of 250% of the Federal Poverty Guidelines, and
2. All other payment options have been exhausted for the patient including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third parties, unless prohibited by local, state, or federal laws.

Discounted Care: For eligible services, Discounted Care will be provided to a patient, or patient's Guarantor meeting the following criteria:

- Uninsured and underinsured patients meeting other eligibility criteria and whose annualized family incomes are in excess of 250% but less than or equal to 500% of the Federal Poverty Guidelines, and
- All other payment options have been exhausted for the patient including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third parties.

Discounts are outlined in the Financial Assistance Patient Responsibility Matrix – Attachment B

Medical Hardship: While Financial Assistance is typically provided in accordance with the established criteria, it is recognized that there may occasionally be a need for granting additional support based on extenuating circumstances.

For eligible services, Discounted Care will be provided to a patient, or patient's Guarantor, meeting the following criteria:

1. Patient, or patient's Guarantor, has annual family income in excess of 500% of the Federal Poverty Guidelines
2. Patient, or patient's Guarantor, has exhausted all other payment options including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third parties; and
3. The out-of-pocket, patient obligations resulting from medical services provided by Intermountain Health providers exceed 25% of annual family income.

Patient, or patient's Guarantor, meeting eligibility criteria for Medical Hardship shall have their Intermountain Health charges limited to 25% of their annual family income. This charge adjustment will apply for all medical services qualified under this provision during a calendar year.

Uninsured Discount: Patients ineligible for financial assistance and having no third-party coverage for Medically Necessary services provided by Intermountain Health will be considered for a discount as covered by the Intermountain Health Patient Discount Policy.

Payment Plans: A reasonable payment plan will be established between Intermountain Health and the patient, or patient guarantor, for any balance remaining after the cost of care has been discounted under the financial assistance policy.

Emergency Medical Services

Intermountain Health care sites shall provide individuals requesting emergency care, or those for whom a representative has made a request if the patient is unable, a medical screening examination to determine whether an emergency medical condition exists. Intermountain Health care sites will not delay examination and treatment to inquire about methods of payment of insurance coverage, or a patient's citizenship or legal status.

Intermountain Health care sites shall treat an individual with an emergency medical condition until the condition is resolved or stabilized and the patient is able to provide self-care following discharge, or if unable, can receive needed continual care. Inpatient care will be provided at an equal level for all patients, regardless of ability to pay. Intermountain Health care sites will not discharge a patient with an emergency medical condition prior to stabilization if the patient's insurance is canceled or otherwise discontinues payment during course of stay.

If an Intermountain Health hospital does not have the capability to treat the emergency medical condition, it will make an appropriate transfer of the patient to another hospital with such capability.

Basis for Calculating Amounts Charged to Patients

Intermountain Health will not charge patients eligible for Financial Assistance under this policy for emergency or other Medically Necessary care more than the AGB to individuals who have insurance. Individuals may request the AGB percentage in effect at any particular time by contacting the Financial Counseling Department or the Billing office contact links included in the Secondary Materials section below.

Intermountain Health uses a look back method to calculate the AGB percentage at least annually by dividing the sum of all claims that have been paid in full by Medicare and all private health insurers together as the primary payer of those claims during the prior twelve (12)-month period by the sum of the associated Gross Charges for those claims.

Applying for Financial Assistance

Financial assistance eligibility determinations will be made based on the Intermountain Health policy and an assessment of financial need. Uninsured and underinsured patients will be informed of the financial assistance policy and the process for submitting an application. Patients, or patients' guarantors, have a responsibility to cooperate in applying for financial assistance by providing information and documentation on family size and income.

Intermountain Health will first make reasonable efforts to explain the benefits of Medicaid and other available public and private programs to patients, or patients' guarantors, and make available to them information on those programs that may provide coverage for services. Intermountain Health will make affirmative efforts to help patients, or a patients' guarantors, apply for public programs, private programs and COBRA coverage, for which they may qualify and that may assist them in obtaining and paying for health care services. Patients identified as potentially eligible will be expected to apply for such programs.

Information on external coverage and the financial assistance policy of Intermountain Health will be communicated to patients in a manner that is easy to understand, culturally appropriate and in the most prevalent languages used in their communities.

Application and Documentation: All applicants must complete the regional specific Financial Assistance application form and may need to provide requested documents when applying for Financial Assistance. Documentation may include:

1. Income information such as recent pay stubs, supporting documentation for self-employment income, the most recent income tax return and bank statements;
2. Monthly expense details (as outlined on the Financial Assistance application form); and/or
3. Other supporting documentation as outlined in the Intermountain Health policy and on the Financial Assistance application form may include:
   - Medicaid Denial Letter, if applicable
   - Divorce Decree, or legal separation notice, if applicable
   - Proof of death, if applicable. This can be demonstrated by providing a death certificate, death notice, funeral home notice, etc.
   - Proof of Humanitarian Service mission, if applicable
   - Letter of support, if applicable
   - External Medical Debt statements if over $5,000, if applicable

- Eligibility criteria used in the evaluative process includes income in relation to Federal Poverty Level (FPL) set annually by the Federal Department of Health and Human Services based on household size and household income.
- Residency within an Intermountain service area for non-emergent hospital services and/or extenuating circumstances. Trauma and emergency services provided in an emergency setting are covered regardless of residency status.
- Patient and/or Guarantor should explore all available funding sources including government and private assistance programs before applying for Financial Assistance. Intermountain Health can help patients apply for assistance from non-Intermountain Health sources.

Presumptive Eligibility

Intermountain Health recognizes that not all patients, or patients' Guarantors, are able to complete the Financial Assistance application or provide requisite documentation. Financial Counselors are available at care sites to assist any individual seeking application assistance. For patients, or patients' Guarantors, who are unable to provide required documentation but meet certain financial need criteria, Intermountain Health may grant Financial Assistance. In particular, presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;
2. Homeless or one who received care from a homeless clinic;
3. Participation in Women, Infants and Children (WIC) programs;
4. Food stamp eligibility;
5. Subsidized school lunch program eligibility;
6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
7. Low income/subsidized housing is provided as a valid address
8. Eligibility based on health care industry sources of information (e.g., public record data, socioeconomic information, vendor calculated scores).

For patients, or their guarantors, who are non-responsive to the Intermountain Health application process, other sources of information may be used to make an individual assessment of financial need. This information will enable Intermountain Health to make an informed decision on the financial need of non-responsive patients.

For the purpose of helping financially needy patients, Intermountain Health may utilize a third-party to review a patient's, or the patient's guarantor, information to assess financial need. This review utilizes a health care industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socio-economic and financial capacity score. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for Intermountain Health. The predictive model enables Intermountain Health to assess whether a patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process.

Information from the predictive model may be used by Intermountain Health to grant presumptive eligibility to, or relax some of, the documentation requirements for patients or their guarantors. In cases where there is an absence of information provided directly by the patient, and after efforts to confirm coverage availability, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

In the event a patient does not qualify under the presumptive rule set, the patient may still provide requisite information and be considered under the traditional financial assistance application process.

Deceased Patients: If the Deceased is not married, has no established estate, and meets the criteria for adjustment, the account will be routed for adjustment review. To confirm estate status, a charity representative will submit an inquiry to the county of residence of the Deceased. Account details will be included, reflecting the remaining balance on the account.

If the Deceased has a Surviving Spouse, the state law where the Deceased resided will determine if the balance becomes the responsibility of the Surviving Spouse or the estate of the Deceased. If the Surviving Spouse is responsible, the account will be assigned to the spouse. The Surviving Spouse can apply for Financial Assistance if the state laws determine that debt of the Deceased becomes the responsibility of the Surviving Spouse. The Surviving Spouse will need to complete the application for Financial Assistance and provide any required documentation. The account will then undergo Financial Assistance review to determine eligibility.

Financial Assistance Approvals

Financial assistance determinations will be made according to the approved policy and in a manner that reflects financial stewardship and social responsibility. Adjustments will follow the levels as established in the Intermountain Health policy.

Timeline for Establishing Financial Eligibility

Determination for Financial Assistance can be made during any stage of the patient's care after stabilization of medical condition or during the collection cycle. Determination will be made after all efforts to qualify the patient for other public or private programs have been exhausted. If other avenues of financial support are being pursued, Intermountain Health will communicate with the patient, or patient's Guarantor, regarding the process and expected timeline for determination and shall not attempt collection efforts while such determination is being made.

Requests for Financial Assistance shall be processed promptly, and Intermountain Health shall notify the patient or applicant in writing within a reasonable timeframe. If eligibility is approved, the patient will be granted Financial Assistance for a period of twelve months. Financial Assistance will also be applied to all eligible accounts incurred for services received prior to application date. If denied Financial Assistance, a patient, or

patient's Guarantor, may re-apply whenever there has been a change of income or status. A Financial Assistance application will need to be re-submitted if more than six months has transpired since initial denial.

Notification about Financial Assistance

Information on Financial Assistance policies or programs is readily available and posted on all Intermountain Health websites. Additionally, the availability of Financial Assistance will be conspicuously posted in emergency departments, urgent care centers, admitting and registration areas, and other locations that Intermountain Health deems appropriate. Signs and other information on Financial Assistance are available in other languages that represent at least 5% of the patients served annually by the specific care site.

In addition to the methods noted above, Financial Assistance policies or program summaries are made available to appropriate community health and human services agencies and other organizations that assist people in need. Financial Assistance information, including a contact number, shall be included in patient bills and through oral communication. Information about Financial Assistance is available at points of registration. Financial counseling is available to patients to help them manage their Intermountain Health bills. It is the responsibility of the patient or the patient's Guarantor to schedule assistance with a Financial Counselor.

Intermountain Health educates caregivers who work closely with patients (including those working in patient registration and admitting, Financial Assistance, customer service, billing and collections) about Financial Assistance and collection policies and practices. Referral of patients for Financial Assistance may be made by any Intermountain Health caregiver or medical staff, including physicians, nurses, Financial Counselors, social workers, case managers, chaplains and religious sponsors.

Appeals & Dispute Resolution

Patients may seek a review from Intermountain Health in the event of a dispute over the application of this Financial Assistance policy. Patients denied Financial Assistance may also appeal their eligibility determination. Disputes and appeals may be filed by contacting the Financial Assistance leadership. The basis for the dispute or appeal should be in writing and submitted within 90 days of Financial Assistance determination.

Intermountain Health may provide Financial Assistance for certain items that are reasonably connected to the medical care of an uninsured individual, underinsured individual, or not covered by the individual's health plan. Please see Financial Assistance-Items Related to Medical Care in the secondary materials.

Refer to Intermountain Health Hospital Locations – Attachment A for a listing of Intermountain Health hospital locations for the submission of any disputes or appeals.

Record Keeping

Intermountain Health will document financial assistance, whether fully discounted (no charge) care, discounted care or medical hardship in order to maintain proper controls and meet all internal and external compliance requirements.

Actions in the Event of Non-Payment

Intermountain Health will make certain efforts to provide uninsured patients with information about our financial assistance policy, such as including a summary of it with billing statements before Intermountain Health or our collection vendors take certain actions to collect payment. Intermountain Health collection policies shall comply

with federal and state regulations and laws governing health care billing and collections. No documentation information obtained through the application process will be used for collection actions.

No extraordinary collection actions will be pursued against any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance. Reasonable efforts shall include, but not be limited to, validating that the patient owes the unpaid bills and that all sources of third-party payments have been identified and billed Intermountain Health. Reasonable efforts also include a prohibition on collection actions pursued against an uninsured patient (or one likely to be underinsured) until the patient has been made aware of the care site's financial assistance policy and has had the opportunity to apply for it or has availed themselves of a reasonable payment plan. The care sites will refrain from extraordinary collection actions against a patient if they provide documentation that they have applied for health care coverage under Medicaid, or other publicly-sponsored health care programs.

The Intermountain Health policy requires that information on financial assistance be included in all statements sent to patients informing them of any outstanding balance due. Additionally, the care sites and/or care sites business associates shall contact non-responsive patients, using oral and written means of communication, to inform them of outstanding balances owed and to discuss eligibility for financial assistance or reasonable payment options.

Regulatory Requirements

In implementing this policy, Intermountain management and facilities shall comply with all other federal, state, and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.

Exclusions

The Following care sites are not covered by this policy:

- Mount Saint Vincent
- Saltzer Health clinics
- Tellica Imaging locations

Policy Approval

The Intermountain Health financial assistance policy is subject to periodic review. Any changes to the policy must be approved by the Intermountain Health Board of Directors

References and/or Primary Sources:

HHS Poverty Guidelines for 2022

Related Policies and/or Guidelines:

- Collections & Bad Debt Policy
- Patient Discount Policy

Supporting Documents

- Covered Providers – Idaho, Nevada, and Utah
- Covered Providers – Colorado, Kansas, and Montana
- Financial Assistance Application
- Financial Assistance Excluded Hospital Services
- Financial Assistance Sliding Scale Discount Table
- Financial Counseling Contact – Idaho, Nevada, and Utah
- Financial Counseling Contact – Colorado and Montana

ATTACHMENT A

Disputes and appeals may be filed by contacting Financial Counseling Leadership for Financial Assistance Program.

Idaho, Nevada or Utah:

Financial Assistance Program
P.O. Box 30193
Salt Lake City, UT 84130

Colorado, Kansas or Montana:

Financial Assistance Program
500 Eldorado Blvd.
Broomfield, CO 80021

Intermountain Health Hospitals:

Colorado:

Good Samaritan Hospital
200 Exempla Circle
Lafayette, CO 80026

Lutheran Hospital
8300 W 38th Avenue
Wheat Ridge, CO 80030

Platte Valley Hospital
1600 Prairie Center Pkwy
Brighton, CO 80601

St Joseph Hospital
1375 East 19th Avenue
Denver, CO 80218

St Mary's Regional Hospital
2635 N. 7th Street
Grand Junction, CO 81501

Idaho:

Cassia Regional Hospital
1501 Hiland Ave
Burley, ID 83318

Montana:

Holy Rosary Hospital
2600 Wilson Street
Miles City, MT 59301

St. James Hospital
200 S. Clark Street
Butte, MT 59701

St. Vincent Regional Hospital
1233 N. 30th Street
Billings, MT 59101

Utah:

Alta View Hospital
9660 S 1300 E
Sandy, UT 84094

American Fork Hospital
170 N 1100 E
American Fork, UT 84003

Bear River Valley Hospital
905 N 1000W
Tremonton, UT 84337

Fillmore Community Hospital
674 UT-99
Fillmore, UT 84631

Layton Hospital
201 W Layton Pkwy
Layton, UT 84041

Intermountain Medical Center
5121 Cottonwood St.
Murray, UT 84107

Logan Regional Hospital
1400 N 500 E
Logan, UT 84341

Orem Community Hospital
331 N 400 W St
Orem, UT 84057

McKay-Dee Hospital
4401 Harrison Blvd
Ogden, UT 84403

Utah (*cont.)*

Primary Childrens Hospital
100 Mario Capecchi Dr
Salt Lake City, UT 84113

Riverton Hospital
3741 W 12600 S
Riverton, UT 84065

Sanpete Valley Hospital
1100 S Medical Dr
Mt Pleasant, UT 84647

Spanish Fork Hospital
765 E Mkt Pl Dr
Spanish Fork, UT 84660

Sevier Valley Hospital
1000 N Main St
Richfield, UT 84701

Park City Hospital
900 Round Valley Dr
Park City, UT 84060

Utah Valley Hospital
1034 N 500 W
Provo, UT 84604

Cedar City Hospital
1303 N Main St
Cedar City, UT 84721

Heber Valley Hospital
454 East Medical Way
Heber City, UT 84032

LDS Hospital
8th Avenue, C ST E
Salt Lake City, UT 84143

Orthopedic Specialty Hospital
5848 S 300 E
Murray, UT 84107

ATTACHMENT B

Financial Assistance Patient Responsibility Matrix

Attachment B

2024	Percentage of Federal Poverty Guideline																		
Sizes of Household	0%	to	250%	251%	to	300%	301%	to	350%	351%	to	400%	401%	to	450%	451%	to	500%	*501% +
1	$ -	to	$ 37,650	$ 37,651	to	$ 45,180	$ 45,181	to	$ 52,710	$ 52,711	to	$ 60,240	$ 60,241	to	$ 67,770	$ 67,771	to	$ 75,300	
2	$ -	to	$ 51,100	$ 51,101	to	$ 61,320	$ 61,321	to	$ 71,540	$ 71,541	to	$ 81,760	$ 81,761	to	$ 91,980	$ 91,981	to	$ 102,200	
3	$ -	to	$ 64,550	$ 64,551	to	$ 77,460	$ 77,461	to	$ 90,370	$ 90,371	to	$ 103,280	$ 103,281	to	$ 116,190	$ 116,191	to	$ 129,100	
4	$ -	to	$ 78,000	$ 78,001	to	$ 93,600	$ 93,601	to	$ 109,200	$ 109,201	to	$ 124,800	$ 124,801	to	$ 140,400	$ 140,401	to	$ 156,000	Self-pay Discount
5	$ -	to	$ 91,450	$ 91,451	to	$ 109,740	$ 109,741	to	$ 128,030	$ 128,031	to	$ 146,320	$ 146,321	to	$ 164,610	$ 164,611	to	$ 182,900	
6	$ -	to	$ 104,900	$ 104,901	to	$ 125,880	$ 125,881	to	$ 146,860	$ 146,861	to	$ 167,840	$ 167,841	to	$ 188,820	$ 188,821	to	$ 209,800	
7	$ -	to	$ 118,350	$ 118,351	to	$ 142,020	$ 142,021	to	$ 165,690	$ 165,691	to	$ 189,360	$ 189,361	to	$ 213,030	$ 213,031	to	$ 236,700	
8	$ -	to	$ 131,800	$ 131,801	to	$ 158,160	$ 158,161	to	$ 184,520	$ 184,521	to	$ 210,880	$ 210,881	to	$ 237,240	$ 237,241	to	$ 263,600	
For each additional person add	$5,380			$5,380			$5,380			$5,380			$5,380			$5,380			*SP Disc*
Clinic Copay	0			*$25*			*$35*			*$50*			*$75*			*$100*			
IP/OP Discount	*100%*			*95%*			*90%*			*85%*			*80%*			*75%*			

**Patient responsibility per visit not to exceed 25% of household income for patients with incomes greater than 500% of the Federal Poverty Level who qualify for a Medical Hardship*

Sliding scale effective 4/1/2024