



PERMANENT ADMINISTRATIVE ORDER

OHP 3-2026

CHAPTER 409

OREGON HEALTH AUTHORITY HEALTH POLICY AND ANALYTICS

FILED: 06/29/2026 2:14 PM

ARCHIVES DIVISION SECRETARY OF STATE & LEGISLATIVE COUNSEL

FILING CAPTION: Hospital financial assistance prescreening criteria raising from \$500 to \$1500 in a single hospital encounter.

EFFECTIVE DATE: 07/01/2026

AGENCY APPROVED DATE: 06/29/2026

CONTACT:

Sarah Grabe
503-339-6666
sarah.grabe@oha.oregon.gov
Portland State Office Building
800 NE Oregon St
Portland, OR 97232

Filed By:

Melanie White
Rules Coordinator

AMEND: 409-023-0120

NOTICE FILED DATE: 05/19/2026

RULE SUMMARY: Hospital financial assistance prescreening criteria raising from \$500 to \$1,500 in a single hospital encounter.

CHANGES TO RULE:

409-023-0120

Requirements for prescreening patients for presumptive eligibility for financial assistance

- (1) Prescreening and presumptive eligibility rules are effective July 1, 2024. ¶
- (2) Hospitals must document their prescreening process in their financial assistance policy. Process documentation must disclose the software products and all other third-party services used to evaluate patient household income for prescreening. ¶
- (3) The prescreening process and presumptive eligibility determination is not considered an application for financial assistance and does not disqualify a patient from seeking financial assistance. ¶
- (4) The prescreening process must use the financial assistance eligibility standards published in the hospital's

financial assistance policy and in accordance with the minimum standards specified in ORS 442.614. Any adjustment to patient cost due to the prescreening process must meet the minimum standards specified in ORS 442.614.¶

(5) Hospitals must complete prescreening for financial assistance and make any resulting adjustments to patient cost prior to sending the patient a billing statement. ¶

(6) Prior to taking any other prescreening actions, the hospital must determine if during the previous nine (9) month period, the patient has applied for financial assistance and the hospital has determined that the patient is eligible for financial assistance based on documentation provided by the patient. If yes, the patient must receive a patient cost adjustment in accordance with ORS 442.614, prior to receiving a billing statement. ¶

(7) Hospitals must prescreen for presumptive eligibility for financial assistance whenever the patient meets any of the following criteria: ¶

(a) Is uninsured; or ¶

(b) Is enrolled in a state medical assistance program; or ¶

(c) Will owe the hospital ~~\$more than \$1,500 for more~~ a single hospital encounter after all adjustments from insurance or third-party payers, if applicable, have been made. ¶

(8) Hospitals may prescreen patients who do not meet any of the criteria in (7) above at the hospital's discretion or as established in the hospital's financial assistance policy. ¶

(9) A hospital must not require a patient to present documentation or other verification related to any eligibility criteria as a condition of prescreening or a requirement for adjustment to the patient costs as a result of prescreening. A hospital may accept voluntary submission of information or documentation that would assist the hospital in the prescreening process as long as the hospital does not compel the patient to provide the information. ¶

(10) Hospitals may use existing patient data in the prescreening process, including but not limited to: ¶

(a) Existing patient records; ¶

(b) Information routinely collected during patient registration or admission; ¶

(c) Information voluntarily supplied by the patient; ¶

(d) Previous financial assistance adjustments; and ¶

(e) Existing eligibility for assistance programs. Examples include, but are not limited to: Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC), free lunch or breakfast programs, low-income home energy assistance programs, or any other programs which are means tested and would reasonably reflect the approximate patient household income. ¶

(f) If a hospital's initial prescreening method fails to return information about the patient, the hospital must make a good faith effort to determine the patient's presumptive eligibility status based on other information available to the hospital. ¶

(11) A hospital may use third-party income verification software tools or services or contract with a third party to conduct the prescreening if: ¶

(a) The process does not cause any negative impact on the patient's credit score; ¶

(b) Evaluations must be based on eligibility criteria established in the hospital's written financial assistance policy. Evaluations by non-profit hospitals must be based on household income only, and cannot consider household assets or any assessment, evaluation or score that predicts the patient's propensity or ability to pay; and ¶

(c) If a third-party service or software tool fails to return information about the patient, or specifies the patient's income is unknown, the hospital make a good faith effort to determine the patient's presumptive eligibility status based on information available to the hospital. ¶

(12) Hospitals must document methods utilized under (10) and (11) they took to prescreen the patient. ¶

(13) A hospital must notify the patient in writing of the results of the prescreening process, regardless of outcome. The notification must meet the following standards: ¶

(a) Be written in plain language and either the preferred language of the patient or otherwise in alignment with the translation standards specified in ORS 442.614; ¶

(b) Delivered by a minimum of one of the following means: ¶

(A) Letter; ¶

(B) Email, if agreed to by the patient as an acceptable form of communication; ¶

(C) Message or notification on an online patient portal if the patient is a registered user of the patient portal; ¶

(D) A prominently displayed notice on the billing statement; ¶

(E) An insert accompanying a billing statement; or ¶

(F) In-person acknowledgement signed by the patient. ¶

(c) Clearly state the outcome of the prescreening using plain language for each of the following outcomes: ¶

(A) Presumptively eligible for full financial assistance; ¶

(B) Presumptively eligible for partial financial assistance; ¶

(C) Not presumptively eligible for financial assistance; or ¶

(D) Unable to determine presumptive eligibility status.¶¶

(d) If the prescreening process determines that the patient is not presumptively eligible, or their eligibility cannot be determined, or the patient cost adjustment was less than 100% of the patient cost amount, the hospital must further state the following information: ¶¶

(A) That the patient may still apply for financial assistance, or additional financial assistance, by using the standard hospital financial assistance application; ¶¶

(B) How a patient may request and receive a physical application or access an online application; ¶¶

(C) How a patient may request assistance in completing the financial assistance application; and ¶¶

(D) That the patient is eligible to apply for financial assistance for at least 240 days following the first billing statement for the services provided or at least 12 months after the patient pays for the services provided, or for any additional time period beyond these minimums as specified in the hospital's financial assistance policies.

Statutory/Other Authority: ORS 442.615

Statutes/Other Implemented: ORS 442.614, 442.615