PURPOSE:

The Uninsured Program has been established to provide financial relief to those who are unable to meet their financial obligations to Adirondack Medical Center and to assist patients who qualify for insurance in enrolling in the available programs. Eligible patients include all patients regardless of race, religion, or national origins, which meet the financial guidelines, set forth in the current poverty guidelines and are not eligible for or enrolled in the state Medicaid.

PRINCIPLES:

- Fear of a hospital bill should never get in the way of a New Yorker receiving essential health services. Hospitals should proactively convey this message to prospective patients, the public in general, and local community service agencies.
- Hospitals must have financial aide policies that are consistent with the mission, vision and values of the hospital and that take into account each individual's ability to contribute to his or her care and the Hospital's financial ability to provide the care.
- Financial aid policies should be clear and understandable, and communicated in a manner that is dignified and in multiple languages appropriate to the communities and patients served.
- Debt collection policies, by both hospital staff and external collection agencies must reflect the mission and values of the hospital.
- Financial assistance provided by the hospital is not a substitute for the responsibility of government and employers to find solutions to expand access to health care coverage for all New Yorkers.
- Financial aid policies do not eliminate personal responsibility. Eligible patients are encouraged to access public or private insurance options. All patients are expected to contribute to their care based on their individual ability to pay.

PROCEDURE:

1. All patients that present at any Adirondack Medical Center's registration site who are self-pay will be provided with information on Uninsured Program/Enrollment Process and the benefits of this program (i.e. 30% off total charges).
2. Bill status is put in "enrollment pending" for 15 days for patient to make an appointment with the enrollment office. This bill status will ensure that no billing process will occur until enrollment process is complete or the patient initiates no activity for 15 days.
3. If patient presents to enrollment office, no billing process will occur until eligibility determination is made.
4. If patient does not visit the enroller within 15 days of the service, the patient will be charged 100% of total charges.

5. If enrollment process is successful but Insurance Plan does not retroactive the eligibility date, all previous bills will be credited towards Charity Care.

6. If all enrollment processes fail and patient does not qualify for any of the Insurance Plans, a Charity Care application will be sent. The bill status will change from “enrollment pending” to “charity care pending”. No billing process will be started until this process is complete.

7. If a patient qualifies for charity care, all previous balances will be adjusted off to the appropriate charity care adjustment charge code.

8. If patient does not respond within 45 days of receipt of Charity Care Application, the billing process will be reinstated and a statement generated reflecting the 30% discount (for going through the enrollment process) will be sent.

9. If the patient does not visit the enroller or apply for Charity Care in 60 days, the patient will charged 100% of total charges.

CHARITY CARE POLICY:

1. Eligibility - Patient eligibility will be based on the following information:

   A. Proof of New York Residency
   B. Patient’s (or responsible person’s) financial need in relation to his/her income, resource level and ability to meet normal living expenses, as determined from charity care application. Current poverty guidelines will be utilized for comparison.
      a. The charity application includes:
         • Income from all sources listing gross income for the most recent three-month period (income for seasonal employees will be based on a 12 month average). Resources from savings and checking accounts, certificate of deposit, stocks, bonds real estate, etc.
         • Monthly expenses and number of dependants.
         • A copy of the most recent federal income tax form

*** This information may be obtained from information already provided to the facilitated enroller***

C. Patient must apply for and be denied Medicaid, Child Health Plus or Family Health Plus. A copy of these denials must be provided to Adirondack Medical Center before final determination can be made.

D. All hospital services are eligible for Charity Care (i.e. inpatient, outpatient, ambulatory surgery, emergency room, etc.). Charity Care does not cover services provided by medical personnel who are not employed by Adirondack Medical Center (i.e. radiologists, anesthesiologists, surgeons, orthopedics, internal medicine, psychiatry, pathologists, etc). Balances previously sent to collection agency will be considered for charity care if not older than six (6) months.
E. Upon visit to enroller, all accounts will remain on “enrollment pending” hold for an additional 35 days (total of 45 days from point of the registration process) to allow time for the enrollment process to be completed and Charity Care application to be provided if necessary. The Self Pay Account representative will run weekly reports and communicate with enroller to find out status of enrollment or denial. If patient was denied or did not qualify for any programs, Charity Care Application will be sent. If application is not returned within 45 days, account will be released from “enrollment pending” and statements will be reinstated reflecting the 30% discount off total charges.

2. Program Administration – The Charity Care Program will be administered according to the following guidelines:

A. The application information as well as proof of income (pay stubs, income tax forms, W-2’s, etc), and Medicaid, Child Health Plus or Family Health Plus denial information will be reviewed and verified by a Patient Financial Services account representative.

B. After reviewing income and expenses, patient financial services personnel will determine if the patient/guarantor qualifies for charity care benefits based on the income and asset information provided previously through the enrollment process.

C. Patient/guarantor will be notified of charity care determination within 10 days of receipt of all required information.

D. Adirondack Medical Center reserves the right to change benefit determination if financial circumstances have changed.

E. All applications will be processed by the Self Pay Account Representative and co-signed by the Patient Financial Services Director unless the amount exceeds $10,000. The Vice President of Finance will review and co-sign all amounts over $10,000.

F. Coverage will be retroactive for six months prior to the receipt of the completed application by the Business Office.

G. Applicants may request a review of denial with the Vice President of Finance within thirty (30) days of receipt of such denial.

H. Approved applications will be valid for three (3) months. An updated application must be submitted for continued coverage.

I. Once approval has been granted, all applicable accounts will be adjusted using the “Charity Care” adjustment code.

J. All applications must be maintained by year in a file kept in the Business Office pending future audits.

K. A ledger will be maintained and kept updated as to availability of funds.