BRONX-LEBANON HOSPITAL CENTER
ADMINISTRATIVE MANUAL

Title: Charity Care and Financial Aid Policy
Issued By: Finance Department
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Page No: 1 of 10
Function: LD

PURPOSE
The BronxCare Network, composed of Bronx-Lebanon Hospital Center (“BLHC”) and Dr. Martin Luther King, Jr. Health Center (“MLK”) (each, an “Institution”), recognizes that many persons in our community require medically necessary health care services, but are uninsured or underinsured and, therefore, may not have adequate financial resources to pay for these health care services. This Charity Care and Financial Aid Policy (the “Policy”) reflects our commitment to provide charity care and financial assistance to persons in our community in furtherance of our charitable mission as a major voluntary healthcare provider committed to Excellence in Healthcare Services, Medical Education and Research. This Policy may be applied to other affiliates of the BronxCare Network, as determined by their respective governing boards.

POLICY
In furtherance of the Institution’s charitable mission, it is our Policy to provide Charity Care and Financial Aid to eligible patients who cannot afford to pay for all or a portion of medically necessary services, including insurance co-insurances, insurance deductibles, and balances after exhausted coverage or other benefit coverage. Due to Federal Regulations, Medicare co-insurances and deductibles will be handled on a case by case basis. If a person other than patient requests information regarding this Policy, such information should, if possible, be provided at the time of the request. Our goal is to provide prompt, clear and understandable information that is consistent and is communicated in the patient’s primary language, generally English or Spanish.

Charity Care and Financial Aid require the expenditure of significant resources and funds by the Institution. Such expenditures include “Charity Care,” i.e., free care, and “Financial Aid,” i.e., discounts, reduced payments and extended payment schedules. Eligibility for Charity Care or Financial Aid under this Policy should be based on an individual determination of the patient’s needs and available resources.

The Institution’s financial commitment to Charity Care and Financial Aid will be established annually as part of the budget process and will be approved by the Institution’s Board of Trustees. The Institution’s debt collection policies, e.g., criteria for commencing a collection action and implementing post-judgment collection remedies, should be consistent with this Policy. Contracted collection agencies and/or collection attorneys should act in a manner that is consistent with this Policy.

GENERAL PRINCIPLES
As set forth in further detail below, Charity Care and Financial Aid are available for medically necessary services to those persons who reside in our community and who meet stated criteria. To the extent
reasonably possible, a patient should be evaluated for eligibility for Charity Care or Financial Aid when he/she initially presents for inpatient or outpatient care.

Charity Care and Financial Aid are available to persons:

- Who reside in the Institution’s Service Area, which is defined as the five boroughs, to include The Bronx, New York, Queens, Kings and Richmond and the county of Westchester; for emergent services all New York State zip codes are included, and
- Who are self-pay, have no health care coverage or governmental assistance, such as Medicaid, Family Health Plus or Child Health Plus, and cannot qualify for governmental assistance despite reasonable efforts to obtain such assistance, and
- Whose income falls within 300% of the Federal Poverty Guidelines, but exceptions may be made on an individual basis due to extraordinary circumstances, as provided in this Policy.
- In addition, low income and, in some cases, middle income, persons who are unable to meet his/her financial obligations for medically necessary services due to the extraordinary high cost of those services, inadequate insurance coverage or similar reasons, may qualify on a case-by-case basis for Financial Aid under this Policy.

Experience has shown that many persons receiving medical care at the Institution would qualify for such governmental programs, if they provided the necessary information and documentation. Staff should assist the patient with completing an application to any applicable governmental program, but the patient should provide the necessary information and documentation and, preferably, sign the application. The application process should be completed while the patient is an inpatient or at the time of the current, but not later than the next, scheduled outpatient service.

If the patient refuses to cooperate, he/she will be treated as a “self-pay” patient. Any failure to cooperate under this Policy should be noted in the patient’s financial file and be considered when the patient next requests elective services.

The determination that a patient qualifies for Charity Care or Financial Aid will be re-evaluated (a) at each inpatient admission, and (b) at least every 12 months for outpatient services. Staff should request if there has been a change in financial circumstances, which may affect a patient’s eligibility under this Policy. If there is a change, the patient’s status should be updated.

This Policy generally requires a financial commitment by each patient to reinforce the principle that the patient has some degree of financial responsibility for his/her medical care. If the patient cannot make the payment required by this Policy when the services are provided, the patient should be permitted to receive the current service, but he/she will be informed payment will be required when the next elective service is provided. If applicable, the Institution should also determine if a patient is eligible for an extended payment plan.

**Approval Process**

If a patient is determined to be eligible under this Policy, the following approvals will be obtained based on the level of Charity Care or Financial Aid that is being proposed:

- Up to $5,000 will be approved by a Supervisor of Patient Financial Services.
- From $5,001 to $20,000 will be approved by the Director of Patient Financial Services.
- From $20,001 to $100,000 will be approved by the Vice-President, Finance and Revenue Management.
- In excess of $100,000 will be approved the Chief Financial Officer.
Reconsideration Process

If a patient is determined to be ineligible under this Policy, the denied application and the reason(s) for the denial, including but not limited to failure to cooperate in the application process, will be noted in the patient’s financial file. The patient should be informed that he/she is permitted to request reconsideration of his/her application, by the following:

<table>
<thead>
<tr>
<th>Institution</th>
<th>Administrative Designee</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLHC - Inpatient Services</td>
<td>Medical Director</td>
</tr>
<tr>
<td>BLHC - Outpatient Services</td>
<td>Assistant VP, Practice Management</td>
</tr>
<tr>
<td>MLK</td>
<td>Executive Director</td>
</tr>
</tbody>
</table>

Determining Patient Eligibility under this Policy for Inpatient and Outpatient Services

1. When registering or scheduling a patient, responsible Staff should inform all self-pay patients of this Policy, and, assist the self-pay patient in determining eligibility under this Policy. A “self-pay” patient does not have health insurance and does not receive benefits from a governmental assistance program, such as Medicaid, Family Health Plus or Child Health Plus. Responsible Staff will usually be:
   a. The Financial Investigator or Medicaid Eligibility Specialist for inpatient services, or
   b. The Registrar/Receptionist, Financial Screener or Call Center Associate for outpatient/clinic services.

2. Self-pay patients who reside in the Institution’s Service Area, as defined above, should complete an application for assistance under this Policy and any applicable governmental program and provide supporting documentation of identity, address, household income and household composition.

3. Staff will refer patients who may be eligible for governmental assistance, such as Medicaid, Family Health Plus, or Child Health Plus, to the appropriate program, e.g., Fulton HRA Office for Medicaid or the Department of Managed Care.

4. Staff will review the application and determine if the patient qualifies for Charity Care or Financial Aid under this Policy.

5. Eligibility should be determined prior to elective ordered ambulatory diagnostic and High Cost Outpatient services, such as MRI, CAT Scan, PET Scan, or LINAC.

6. If the patient is eligible, Staff will determine what level of Charity Care and Financial Aid is applicable, as well as the patient’s financial commitment under this Policy. The patient, legal guardian or financially responsible person, as the case may be, should be advised of the determination, and each of these determinations should be documented in the patient’s file.

7. The patient will receive a bill for the services provided. This bill should state that amount which is being provided as Charity Care or Financial Aid and that amount which is the patient’s financial obligation. Generally, the patient’s financial obligation will be a fixed amount for outpatient services or a percentage of what Medicaid would have paid for inpatient services.
Example – Determination of Patient’s Financial Obligation

The patient’s application shows annual family income of $27,000 and there are 4 family members. The patient would fall within 150% of the Federal Poverty Guidelines.

Inpatient Services: the patient would be financially responsible for 20% of the Medicaid rate\(^1\) and the balance in charges would be Charity Care and Financial Aid.

For example:

<table>
<thead>
<tr>
<th>Inpatient Charges:</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG XXX (Medicaid Rate)</td>
<td>$4,000</td>
</tr>
<tr>
<td>Patient’s Financial Obligation (20% of $4,000 Medicaid Rate)</td>
<td>800 (Includes HCRA Surcharge applicable to Self-Pay Patients)</td>
</tr>
<tr>
<td>Charity Care and Financial Aid Provided</td>
<td>$9,200</td>
</tr>
</tbody>
</table>

General Outpatient Services: the patient would be financially responsible for the fixed payment of $30 and the balance in charges would be Charity Care and Financial Aid.

High Cost Outpatient Services: the patient would be financially responsible for 20% of the Medicaid rate and the balance in charges would be Charity Care and Financial Aid.

8. Staff should review the patient’s outstanding financial obligations when the patient arrives for outpatient services. If a patient has not made a payment between his/her last and current visit or within 60 days from his/her last visit, the case should be referred to the Practice Administrator or his/her designee, and, if necessary, discussed with the Medical Director, or his designee.

9. The patient is allowed 90 days from the date of discharge or of service to apply for financial assistance and 20 days to submit a completed application (including all required documentation). A written response to all completed applications for Charity Care or Financial Aid approving or denying the application will be sent within 30 days after receipt of a completed application. If an application is not complete, the patient should be requested to provide the necessary information to complete the application. If the patient does not provide the requested information within the allowed timeframes, the application may be denied.

10. Once a completed application, including required documentation or other information needed to make a determination on the request for Charity Care or Financial Aid has been submitted, the patient could disregard any bill that has been sent until the hospital had rendered a decision on the application.

11. Eligible patients may request an extended payment plan. Installment payments will not be greater than 10% of gross monthly income.

---

\(^1\) The Patient’s financial responsibility includes the applicable HCRA Surcharge for inpatient and outpatient services.
**Collection Proceedings**

This policy will:

- Prohibit the forced sale of or foreclosure on the patient’s primary residence
  
  i. Note: Liens on the primary residence would continue to be allowed

- Prohibit sending an account to collection if the patient has submitted a completed application for financial assistance, including any required documentation, while the application is pending.

- Provide written notification to a patient at least 30 days before an account is sent to collection. Written notice could be included on a bill.

- Require the collection agency to have the hospital’s written consent prior to starting a legal action for collection.

- Require general hospital staff that interact with patients or have responsibility for billing and collection to be trained in the hospital’s policies.

- Require any collection agency under contract with the hospital to follow the hospital’s financial assistance policy and provide information to patients on how to apply, where appropriate.

- Prohibit collection activity if the patient is determined eligible for Medicaid for the services that were rendered and the hospital is able to collect Medicaid payment.

**Board Oversight/Patient Notification/Staff Training**

- The Chief Financial Officer shall report to the Board of Trustees annually, or as otherwise requested, regarding the implementation of this Policy.

- Patients should be notified of this Policy as part of the admission package for inpatients and when registering for outpatient/clinic services.

- Notices should be posted in conspicuous locations (e.g., admitting office, registration office, emergency room, billing office and principal waiting rooms).

- The Institution’s bill for medical services should provide patients with basic information regarding this Policy and how to apply for Charity Care or Financial Aid. Patients should be encouraged to request information regarding this Policy.
EXHIBIT A
CHARITY CARE AND FINANCIAL AID POLICY
CHECKLIST

The determination for Charity Care or Financial Aid should be re-evaluated (a) for each inpatient admission, and (b) at least every 12 months for outpatient services. If a change in financial circumstances is identified earlier, an updated evaluation should be completed.

1. The following criteria should be reviewed at the time of the application, and may be reviewed, as necessary upon each subsequent inpatient admission or outpatient visit:

The patient must reside in the Institution’s Service Area, which is defined to be following: the five boroughs, to include The Bronx, New York, Queens, Kings and Richmond and the county of Westchester. For emergent services all New York State zip codes are included. In extraordinary circumstances, persons residing outside the Service Area may be considered for Charity Care and Financial Aid, subject to the approval of the Chief Financial Officer, in consultation with the patient’s attending physician or the Medical Director.

a. Gross income generally should fall within 300% Federal Poverty Guidelines with consideration to family size, geographic area and other pertinent factors, all as set forth in Appendix A.

b. Verification of Income should be provided with the application. Acceptable verification may include:
   i. Prior Year Tax Returns
   ii. Current Pay Stubs
   iii. Written verification of wages from Employer
   iv. Unemployment Letter
   v. Social Security check
   vi. Bank Statement
   vii. Disability check

c. For categories = < 100% Federal Poverty Guidelines and => 101% and < 150% Federal Poverty Guidelines no assets are to be considered in determining eligibility.

d. For categories => 151% and < 250% Federal Poverty Guidelines and => 251% and <=300% Federal Poverty Guidelines the following assets are not to be considered in determining eligibility:
   - The patient’s primary residence
   - Tax-deferred or comparable retirement savings accounts
   - College savings accounts
   - Cars used by the patient or the patient’s immediate family
2. If a patient does not receive governmental benefits, such as Medicaid, Child Health Plus or Family Health Plus, but it appears that he/she would qualify, the patient will be requested to apply for such benefits and Staff will assist the patient with the application. If the application is denied, the patient will be considered for Charity Care or Financial Aid under this Policy.

3. Determine the appropriate amount of Charity Care or Financial Aid based upon the Sliding Fee Scale. A patient who can afford to pay for a portion of the services will be expected to do so.

4. If the patient does not pay the amount deemed to be his/her responsibility, the uncollectible remainder would become bad debt.

5. Homeless patients without a valid address who have not been approved for a funded program will be considered for Charity Care or Financial Aid under this Policy.

6. While patients who fall within the Sliding Fee Scale will be eligible for Charity Care, a patient's status should be re-evaluated if and when:
   a. A new source of insurance or health care funding is identified;
   b. A change in income is identified;
   c. A change in family size is identified, or
   d. Part of the patient’s account is written off as a bad debt or is in collection.

7. All pertinent documents supporting a patient’s eligibility under this Policy should be copied and included in the patient’s record. Initial approvals of applications under this Policy should be based on the supervisor’s review of the documentation submitted by the patient.

8. All Registrar/Receptionist, Financial Investigators, Administrators, or Finance Office Staff who interact with the patient should advise the patient of this Policy.
EXHIBIT B1  (EFFECTIVE 4/1/2009)
CHARITY CARE AND FINANCIAL AID POLICY
2009 FEDERAL POVERTY GUIDELINES (UPDATE ANNUALLY)

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Category of Charity Care and Financial Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>100% = &lt; of Federal Poverty Guidelines</td>
</tr>
<tr>
<td>1</td>
<td>10,830.00</td>
</tr>
<tr>
<td>2</td>
<td>14,570.00</td>
</tr>
<tr>
<td>3</td>
<td>18,310.00</td>
</tr>
<tr>
<td>4</td>
<td>22,050.00</td>
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<tr>
<td>5</td>
<td>25,790.00</td>
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<tr>
<td>6</td>
<td>29,530.00</td>
</tr>
<tr>
<td>7</td>
<td>33,270.00</td>
</tr>
<tr>
<td>8</td>
<td>37,010.00</td>
</tr>
<tr>
<td>9</td>
<td>40,750.00</td>
</tr>
<tr>
<td>10</td>
<td>44,490.00</td>
</tr>
</tbody>
</table>

2 For family units with more than 10 members, add $3,740, $4,675, $5,610, $7,480, $9,350 and $11,220 to Column F, G, H, I, J, and K respectively, for each additional member.
<table>
<thead>
<tr>
<th>Category of Charity Care and Financial Aid</th>
<th>Income as a Percentage of the Federal Poverty Guidelines</th>
<th>General Outpatient Services</th>
<th>Inpatient or High Cost Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Up to 100% of Federal Poverty Guidelines</td>
<td>$0</td>
<td>0% of Medicaid Rate</td>
</tr>
<tr>
<td>G</td>
<td>101 - 125 of Federal Poverty Guidelines</td>
<td>$15</td>
<td>10% of Medicaid Rate</td>
</tr>
<tr>
<td>H</td>
<td>126 - 150% of Federal Poverty Guidelines</td>
<td>$30</td>
<td>20% of Medicaid Rate</td>
</tr>
<tr>
<td>I</td>
<td>151 - 200% of Federal Poverty Guidelines</td>
<td>$50</td>
<td>35% of Medicaid Rate</td>
</tr>
<tr>
<td>J</td>
<td>201 - 250% of Federal Poverty Guidelines</td>
<td>$70</td>
<td>50% of Medicaid Rate</td>
</tr>
<tr>
<td>K</td>
<td>251 - 300% of Federal Poverty Guidelines</td>
<td>$105</td>
<td>75% of Medicaid Rate</td>
</tr>
<tr>
<td>L(Self-Pay)</td>
<td>More than 300% of Federal Poverty Guidelines are treated as Self-Pay Patients</td>
<td>Charges</td>
<td>Charges</td>
</tr>
</tbody>
</table>
Use the following to determine the patient’s financial responsibility:

- Determine the annual household income and family size.
- Use the Federal Poverty Guidelines Table (Exhibit B) to determine the eligibility of patient.
- Locate the family size and determine what percentage of Federal Guidelines corresponds to patient’s income, i.e., Column 1, 2, 3, or 4.
- For Inpatient or High Cost Outpatient Services, go to the Eligibility Table and (a) multiply the applicable patient responsibility percentage by the Medicaid rate for those services, including the applicable HCRA surcharge for self-pay patients to determine the amount that the patient should be billed for each discharge or outpatient visit.
- For General Outpatient Services, go to the Eligibility Table and use the co-pay amount set forth in the applicable column, based on the patient’s income and family size, i.e., Row A, B, C, D or E, to determine the patient financial responsibility which should be billed for each outpatient visit.
- Determine whether patient is eligible for an extended payment plan based on income and resources.
- Determine if other factors should be considered in further adjusting the amount of Charity Care or Financial Aid that the patient may receive. The appropriate member of Administration must approve any such exceptions in accordance with this Policy.
I am requesting Charity Care/Financial Aid to help pay for medical care provided by BronxCare Facilities. I understand that I need to give certain information to support my application. I also understand that the BronxCare or its agents will check this information for completeness and accuracy. I understand that filling out this application does not guarantee that I will receive financial assistance. If my application is denied, I will be responsible for my medical bills.

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>A</th>
<th>F</th>
<th>I</th>
<th>X</th>
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<table>
<thead>
<tr>
<th>Account Number</th>
<th>Medical Record Number</th>
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<table>
<thead>
<tr>
<th>L</th>
<th>B</th>
<th>E</th>
<th>X</th>
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<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Social Security Number</th>
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<tbody>
<tr>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Street Address</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>City, State, Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Telephone Number</th>
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<td></td>
</tr>
</tbody>
</table>

**PATIENT/GUARANTOR EMPLOYER INFORMATION**

Employer Name

Employer Street Address

Employer Telephone Number

**FAMILY MEMBERS LIVING IN THE HOUSEHOLD**

<table>
<thead>
<tr>
<th>Name (F, L, M)</th>
<th>Relation</th>
<th>Age</th>
<th>Sex</th>
<th>Insurance</th>
<th>Works(Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**VERIFY CODES**

1. Birth Certificate
2. Baptismal Certificate
3. Marriage Certificate
4. Driver's License
5. Letter (Affidavit)
6. Other:
7. None Provided

**Enter Code for type of insurance shown**

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>Medicare</td>
<td>Other</td>
<td>Possible Child Health Plus</td>
<td>Possible Family Health Plus</td>
<td>None of the Above</td>
</tr>
</tbody>
</table>

**Administrative Account Notes/Special Circumstances**

**FAMILY SIZE**

(Continue Over on to Page 2)
### Patient/Guarantor and Family Income

**For Administration Use Only**

- **Use Only**
- **Verified By ("X" All that apply)**
  - Current Payroll Stubs
  - Prior Year Tax Returns
  - Employer Letter/Letterhead
  - Unemployment Letter
  - Social Security Check
  - Bank Statement
  - Disability Check
  - Other:

  - None Provided

#### Subtotal

<table>
<thead>
<tr>
<th>Weekly</th>
<th>Monthly</th>
<th>Annual</th>
<th>Security</th>
<th>Unemployment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

#### Total

|        |         |        |          |             |

#### Grand Total

|        |         |        |          |             |

#### Other Income

|        |         |        |          |             |

**TOTAL ALL INCOME**

$_____________

### Other Questions

1. If there is no income, what is the source of housing?

2. How much is spent on housing each month?

3. Do you own a home?
   - [ ] YES
   - [ ] NO

4. Do you own other property?
   - [ ] YES
   - [ ] NO

5. List banking references:
   - Name/Branch:
   - Account #:
   - Name/Branch:
   - Account #:

### Patient Attestations and Signature

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I agree to tell you, within 10 days, if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses, or in the persons in the household or of any changes in addresses.
- I understand that I may be asked to prove my statements and that my eligibility statements may be subject to verification by contact with my employer, bank, credit verification and property searches.
- I understand that if I am not eligible for Charity Care/Financial Aid, I will be personally liable for the services rendered by BronxCare facilities.
- I understand I may appeal an unfavorable decision.

**Patient Appeal of Decision?**

- [ ] YES
- [ ] NO

**Assign to?**

- Medical Director (MD)
- AVP, Practice Mgmt (OPD)
- Executive Director (MLK)

**Follow-up Action**

- [ ] Decision Upheld
- [ ] Decision Reversed

**Prepared By**

<table>
<thead>
<tr>
<th>[ ] Date</th>
<th>Date</th>
</tr>
</thead>
</table>

### Other Administrative Actions

1. Patient declines to apply to Charity Care and Financial Aid
2. Patient does not bring in supporting documentation
3. Patient is/expires becomes eligible for other insurance
4. Patient not eligible for other insurance
5. Other (Specify):
6. Updated entry in Lastword
7. This form (and supporting documentation) filed in patient's chart