PURPOSE:

This policy defines the Catholic Health System's policy and procedures for expecting and collecting payments from uninsured patients.

APPLIES TO:

All uninsured patients of the Catholic Health System receiving treatment at one of the Catholic Health System's acute care facilities. Excluding those in a long term care service line (Sub-Acute or Skilled Nursing)

GENERAL STATEMENT OF POLICY AND GOALS:

The mission of the Catholic Health System is to extend the healing ministry of Jesus by improving the health of our communities with emphasis on people who are under-served. Perpetuating our mission to benefit the communities we serve depends on our professional and ethical stewardship of resources. One part of that stewardship involves ensuring that we receive the appropriate reimbursement for the services we provide.

It is the policy of the Catholic Health System to ensure a socially accountable practice for expecting payment from all patients receiving care at one of our facilities. Most patients served by the Catholic Health System are expected to pay for services provided based on rates negotiated by a third party payer or regulated by a governmental agency. This policy is specifically designed to address both expected reimbursement and collection practices for those patients that are uninsured and require care from one of the facilities within the Catholic Health System.

Definitions:

“Contractual Allowances” – is the difference between amount billed at the provider’s established rates and the amount received or to be received from third-party payors based upon a negotiated contractual agreement rate. The contractual allowance is applied to the patient account of any patient whose care is covered by the particular third-party payer.

“Healthcare Assistance Program (HAP) ~ is the Catholic Health System's charity care program establishing the policy and procedures for the provision of a patient account healthcare assistance allowance for uninsured patients who lack the financial resources necessary to obtain healthcare, or an Uninsured allowance for other uninsured patients that do not qualify for the HAP. The program is established and performed in a compassionate and professional manner consistent with all State and Federal laws and regulations. Note: Attachment A contains the specific requirements of the Catholic Health System's Healthcare Assistance Program (HAP).
“Healthcare Assistance Program (HAP) Allowances ~ are the two part allowances that are available to uninsured patient for uninsured accounts, based on each such patient guarantor’s financial resources and ability to pay for healthcare services. The allowances will be available to all uninsured patients with household incomes estimated to be less than 501% of the Federal Poverty Guideline and a PARO score of less than 695. Charges for healthcare services provided to patients who qualify for the HAP Allowances may be adjusted through two separate allowances, the HAP Allowance and the Additional HAP Allowance. The HAP Allowance is based on an Uninsured Contract established based on NYS Law. Each such account is also potentially subject to an Additional HAP Allowance based on a sliding scale of each patient guarantor’s ability to pay as measured through an objective means test that is applied to all eligible patients.

“Patient” ~ shall mean those persons who receive care at one of the Catholic Health System acute care facilities.

“Guarantor” ~ shall mean the person who is financially responsible for the care of the patient, and may be the same person as the patient or the parent of a minor patient.

“Uninsured Account” ~ is the patient account of any uninsured patient as defined below.

“Uninsured Allowance” ~ is the allowance that is available to uninsured patient “Uninsured” accounts, based on each such patient guarantor’s financial resources and ability to pay for healthcare services. The Uninsured allowance will be available to uninsured patients with household incomes over 500% of the Federal Poverty Guideline. Charges for healthcare services provided to patients who qualify for an Uninsured allowance will be adjusted through an Uninsured contractual allowance account.

“Uninsured Patients” ~ are defined as all patients who are uninsured and do not otherwise qualify for any governmental health insurance, governmental health benefit or private health insurance policy, plan or program that provides coverage for any of the healthcare services rendered, and who qualify for charity care as defined by the Catholic Health System’s “Healthcare Assistance Program”.

PROCEDURE:

1. All reimbursement and collection practices engaged in and observed by Catholic Health System employees, contractors and agents will reflect the Catholic Health System’s commitment to the reverence for individual human dignity, the common good and our special concern for and solidarity with the poor and disadvantaged.

2. This Uninsured Payment and Collection Policy applies to all non-elective healthcare services provided to uninsured patients in the inpatient or outpatient acute care setting. This policy does not apply to payment for elective procedures as defined by the Catholic Health System or services provided in a long term care setting (Sub-Acute or Skilled Nursing).

3. Each Catholic Health System acute care facility must ensure that:
a. Its employees, contractors and agents behave in a manner that reflects the policies and values of the Catholic Health System, including treating patients and families with dignity, respect and compassion.

b. Patients on admission are given, and receive, prompt access to charge information for any item or services provided to them.

c. Patients and their families are advised of the Catholic Health System's policies, including the Healthcare Assistance Program and the availability of need-based financial assistance, in easily understood terms and any language commonly used by patients in the community.

d. Patients who do not qualify for Healthcare Assistance Program assistance, but who are in need of financial assistance, are offered reasonable, customary and appropriate extended payment terms or other reasonable and customary payment options that take into account the patient's financial status.

e. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic sponsored facility.

f. Financial counselors are available to assist all patients.

g. Information is posted in the admitting and registration areas, including the Emergency Department, regarding financial assistance available to patients, including but not limited to the Healthcare Assistance Program.

h. Information given and available to patients shall be in the primary languages of patients served by Catholic Health System. A summary of such information and policies shall be available to patients upon request.

4. Healthcare Assistance:

a. Healthcare Assistance and the Healthcare Assistance Program (HAP) are the detailed process and procedures for charity care and other self-pay allowances set forth in Attachment A to, and incorporated into, this Policy.

b. The HAP shall be implemented in a manner that is in accordance with all applicable New York State and Federal laws, rules and regulations.

c. Uninsured patients with income levels estimated to be less than or equal to 110% of the federal poverty level will be eligible for a 100% healthcare assistance discount.

d. Uninsured patients with income levels between 111% and 500% of the Federal poverty level will be eligible for a percentage healthcare assistance discount and a Fixed HAP discount based on the sliding scale included as Attachment B to this Policy.

e. Uninsured patients with income levels over 500% of the Federal poverty level will be eligible for the allowance and/or fixed HAP included as Attachment B.
5. Financial Assistance Determination:
   a. The assessment of an uninsured patient’s ability to pay is based on an objective, good
      faith determination of financial need, means test that will be applied to all uninsured
      patients in the same manner and will consider, at a minimum, all income, all income
      sources, the local cost of living, and family size. Other financial considerations, including,
      but not limited to other medical care obligations and the extent of the patient’s medical
      bills, may also be considered.
   b. Eligibility for financial assistance through the HAP should be made during the first billing
      cycle following the delivery of healthcare services. However, the determination may be
      made at any point in the patient account revenue cycle.
   c. Uninsured patients considered to have the ability to pay, after application of the objective
      means test assessment, will be expected to pay for healthcare services based on the
      Catholic Health System’s established uninsured rate. This uninsured rate is established in
      line with the Catholic Health System’s highest paying or volume third party payer.
   d. Uninsured patients considered to have the ability to pay may be eligible for discounts,
      such as the Prompt Pay Discount, which may be applied.
   e. An appeals process has been established, and is set forth in Attachment D. The appeal
      process shall be available to all uninsured patients who are denied HAP assistance and
      who do not agree with such denial. This appeal process is also available to those
      awarded HAP discounts that are less than expected.

6. Collection Practices:
   a. An uninsured patient account will not be forwarded to a collection agency if the patient has
      completed a Healthcare Assistance Program application and is awaiting response or
      determination.
   b. The forced sale or foreclosure of and uninsured patient’s primary residence, in order to
      satisfy a patient account, shall be prohibited.
   c. Uninsured patients who are participating in the HAP must be notified at least thirty (30)
      days before their account is forwarded to a collection agency.
   d. All collection agencies servicing Catholic Health System accounts must obtain written
      consent from the Catholic Health System before any legal actions is initiated on any
      patient account.
   e. All collection agencies must agree in writing to follow all Catholic Health System financial
      aid policies and procedures.
POLICY AND PROCEDURE

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<th>Uninsured Payment and Collection Policy</th>
<th>RESPONSIBLE DEPARTMENT:</th>
<th>POLICY #:</th>
<th>Page 5 of 7</th>
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</table>

f. Management is accountable to ensure that all collection policies are in accordance with the federal Fair Debt Collection Practices Act and all applicable New York State Law.

g. All collection agencies must provide information to patients on how to apply for financial assistance.

h. All collection agencies are prohibited from making collections from any patient who was eligible for Medicaid at the time services were rendered.

7. Training:

a. Annual mandatory training on Catholic Health System Uninsured policies and its HealthCare Assistance Program will be provided to personnel in Patient Financial Services and Registrations/Admissions.

Origination/Effective Date: TBD

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All policy versions must be maintained for 20 years from the date of replacement or revision

References:

POLICY OWNER: 

PREPARED BY: 

This document is not intended to create, nor is it to be construed to constitute a contract between CHS and any of its employees for either employment or the provision of any benefit. This policy supersedes any and all policies of any CHS organizations and any descriptions of such policies in any handbook of such organization. Personnel failing to comply with this policy may subject to disciplinary action up to and including termination and/or appropriate legal action.
Attachment D

Appeal of Healthcare Assistance Determinations

Applicants Right to Appeal - An appeal procedure has been established which will cover disagreement and/or objection on the part of the applicant to healthcare assistance denials and/or healthcare assistance approvals which may be for less than the total healthcare assistance. That procedure known as “Appeal of Healthcare Assistance Denial Process”, is as follows:

As part of each written notice of determination, applicants will be advised as follows:

If you disagree with, or object to the Catholic Health System decision regarding your application for healthcare assistance, then you may request that the decision be reviewed. A review may be requested in person or via the telephone with the Catholic Health System Financial Clearance Manager. For telephone requests, please contact the Catholic Health System Customer Service Office at 716-601-3600. For in person request, the Catholic Health System Financial Clearance Office is located at:

Apple Tree Business Park, Suite 3550
2875 Union Road
Cheektowaga, NY 14227

Appeal of the determination of healthcare assistance must be submitted within twenty (20) business days of your receipt of the initial statement, which contains the healthcare assistance determination.

If, after reviewing the decision with the Catholic Health System Financial Clearance Manager or other delegated staff members, you are not satisfied, you may request a final appeal of the decision. You will then be entitled to a complete re-evaluation of your application and a written determination of your appeal within thirty (30) days of the date of appeal.

Final Appeal Process

The Financial Clearance Manager will review all final appeals and note the reason for such appeal. In addition, the Financial Clearance Manager will present such other factors as may be pertinent to the appeal regardless of whether such factors may or may not result in a determination in the favor of the applicant.

The Financial Clearance Manager will re-evaluate the application of the appealing applicant in accordance with the requirements of the Catholic Health System program for Healthcare Assistance.

The results of that re-evaluation will be communicated to the applicant in writing within thirty (30) days of the date of the appeal or as soon thereafter as is possible.
The CHS Chief Financial Officer may request a review of the appeal with or by the CHS facilities Chief Executive Officer in the event of circumstances not explicitly or implicitly covered by the criteria or procedures of the Catholic Health System healthcare assistance Program.

A written determination of the final appeal signed by the deciding party or parties will be mailed to the applicant within thirty (30) days of the date of the appeal.

**Appeal Decision Final**

With the exception of extraordinary circumstances, such as additional or revised information that would impact the original decision received after the date of the final appeal decision) all decisions rendered on appeals will be final.

The written notification of determination of a final appeal will not contain any further notice of right of either further review or appeal.
Uninsured Expected Payment and Collection Policy
Attachment A

HEALTHCARE ASSISTANCE PROGRAM

CATHOLIC HEALTH SYSTEM

Updated: July 26, 2007
HEALTHCARE ASSISTANCE PROGRAM

CATHOLIC HEALTH SYSTEM

Statement of Policy

The mission of the Catholic Health System is to extend the healing ministry of Jesus by improving the health of our communities with emphasis on people who are under-served. Perpetuating our mission to benefit the communities we serve depends on our professional and ethical stewardship of resources. One part of that stewardship involves ensuring that we receive the appropriate reimbursement for the services we provide.

It is the policy of the Catholic Health System to ensure a socially accountable practice for expecting payment from all patients receiving care at one of our facilities. Patients served by the Catholic Health System are expected to pay for services provided based on self-pay rates, rates negotiated by a third party payer or regulated by a governmental agency. This Policy is specifically designed to address those patients who are uninsured, require care from one of the acute care facilities within the Catholic Health System and objectively need assistance in covering the costs of these services.

Confidentiality of information and individual dignity will be maintained for all those requesting consideration for healthcare assistance.
HEALTHCARE ASSISTANCE PROGRAM
CATHOLIC HEALTH SYSTEM

I. GENERAL GUIDELINES FOR CATHOLIC HEALTH SYSTEM

A. Definitions

BAD DEBTS – With respect to a patient account, any amount uncollected and determined to be uncollectible, as a result of a patient’s unwillingness to pay after appropriate, diligent and repeated collection efforts, is classified as a bad debt.

CONTRACTUAL ALLOWANCES – The difference between the amount billed at the provider’s established rates and the amount received or to be received from third-party payors based upon a negotiated contractual agreement rate, is the contractual allowance. The contractual allowance is applied to the patient account of any patient whose care is covered by the third-party payor.

HEALTHCARE ASSISTANCE – Healthcare Assistance is the patient account contractual allowance available to uninsured patient’s self-pay accounts, based on each such patient’s financial resources and ability to pay for healthcare services. Healthcare assistance may be either the healthcare assistance allowance or the self-pay allowance, depending upon the patient’s financial resources, as defined herein.

HEALTHCARE ASSISTANCE ALLOWANCES – The healthcare assistance allowances will be available to all uninsured patients with household incomes less than 500% of the Federal Poverty Guideline. Patients with incomes below 300% of the Federal Poverty Guideline are deemed presumptively eligible for an Additional Healthcare Assistance Allowance. Charges for healthcare services provided to patients who qualify for a Healthcare Assistance Allowance will be adjusted in the same fashion as a contractual allowance. Each actual allowance is subject to a sliding scale based on...
HEALTHCARE ASSISTANCE PROGRAM
CATHOLIC HEALTH SYSTEM

each patient's ability to pay as measured through an objective means test that is applied to all eligible patients.

HEALTHCARE ASSISTANCE PROGRAM – The Catholic Health System charity care program through which a healthcare assistance allowance or a self-pay allowance is provided to uninsured patients for the healthcare services they receive. A determination of the eligibility for a healthcare assistance allowance or a self-pay allowance should be made upon admission, prior to discharge, or as soon as possible within a reasonable timeframe, thereafter.

NON COVERED SERVICES - For the purposes of the Healthcare Assistance program, the cost/charges for the following services are not eligible for application of a healthcare assistance allowance and are deemed to be non-covered by the program:

1. Physician services, with the exception of physician services provided at a CHS acute care facility operated primary care site.
2. Services provided in any setting other than in a Catholic Health System acute care facility.
3. Cosmetic surgery or other non-medically necessary services including, but not limited to, requested private room services.
4. Medical equipment and supplies.
5. Long term care services (Sub-Acute and Skilled Nursing)

OTHER SERVICES – The Catholic Health System service area community-based health services provided at a reduced fees to those eligible for healthcare assistance, such as meals, lifeline, health screening, etc.

PATIENTS ELIGIBLE FOR HEALTHCARE ASSISTANCE - Patients eligible for healthcare assistance are those persons who are unable through private resources, employer support, private insurance coverage, governmental insurance coverage such as Medicare, or public assistance such as
HEALTHCARE ASSISTANCE PROGRAM
CATHOLIC HEALTH SYSTEM

Medicaid, to provide payment for the healthcare services they require, and/or those patients who are unable to gain access to healthcare because of limited resources, inadequate education or discrimination.

UNINSURED ACCOUNT ~ An Uninsured Account is the patient account of any uninsured patient. The phrase “uninsured” means that the individual has no other payment source, and that the uninsured patient is solely responsible for the payment of all charges for the healthcare services received from Catholic Health System.

UNINSURED ALLOWANCE ~ The uninsured allowance is patient account contractual allowance available to uninsured patients with household incomes over 500% of the Federal Poverty Guideline. Charges for healthcare services provided to patients who qualify for a uninsured allowance will be adjusted in the same fashion as for a contractual allowance. Each actual uninsured allowance is subject to a sliding scale based on each patient’s ability to pay as measured through an objective means test that is applied to all eligible patients.

SPECIAL SERVICES – Healthcare services provided to patients in situations where a provider’s decision has been made to collect an amount at less than full rates in order to provide a needed service to those eligible for healthcare assistance.

STAFF INVOLVEMENT – Services or contributions provided by Catholic Health System staff to those eligible for healthcare assistance which were not reported or given a dollar value.

UNCOMPENSATED CARE – Uncompensated care means those healthcare services rendered for which the provider is not fully reimbursed or remunerated, either because a patient is uninsured or underinsured or is otherwise unable or unwilling to pay.
HEALTHCARE ASSISTANCE PROGRAM

CATHOLIC HEALTH SYSTEM

UNINSURED PATIENTS - are defined as all patients and responsible persons who are uninsured and do not otherwise qualify for any governmental health insurance, governmental health benefit or private health insurance policy, plan or program that provides coverage for any of the healthcare services rendered, and who qualify for charity care as defined by the Catholic Health System's “Healthcare Assistance Program”.

UNDERINSURED PATIENTS - The term Underinsured Patients, for the purpose of this Policy, shall mean individuals who have health insurance but who have exhausted their benefits and are, in effect, without further insurance coverage for the healthcare services rendered. In such cases, and at such time as the patient has fully exhausted his/her applicable health insurance benefits, an underinsured patient shall be deemed uninsured, for the purposes of this policy. Underinsured patients may be eligible for a healthcare assistance allowance or a self-pay allowance, based upon their available resources and ability to pay for the healthcare services they receive from a CHS facility.

AFTER INSURANCE BALANCE – For most insured patients, there are after insurance balances, that are the sole the responsibility of the patient’s guarantor. These balances include, but are not limited to, co-pays, deductibles and co-insurance.

AFTER INSURANCE BALANCE ALLOWANCE – For insured patients without the financial ability to pay after insurance balances, After Insurance Balance Allowances are available based on the sliding scale included as Attachment C. The procedures specified in section II Procedures, I After Insurance Balance Allowance Procedures must be followed in order to be the eligible for this allowance.

B. Healthcare Assistance vs. Bad Debt

The distinction between declaration of a patient account as a bad debt and the award of healthcare assistance under this HAP is the differentiation between the unwillingness of the patient to pay and the demonstrated inability of the patient to pay. Sound management concepts require that bad debts be distinguished from healthcare assistance so that management can draw informed conclusions as to the effectiveness of the Catholic Health System’s collection efforts and the extent to which each Catholic
HEALTHCARE ASSISTANCE PROGRAM

CATHOLIC HEALTH SYSTEM

Health System facility's resources are being used in caring for those uninsured individuals who are unable to pay for services.

C. Non-Discrimination

Healthcare assistance will be awarded to uninsured patients based solely on their financial resources and ability to pay and will not be abridged on the basis of age, sex, race, religion, or national origin. With the exception of non-covered services, all healthcare services, inpatient and outpatient, provided by any Catholic Health System acute care facility shall be available to all uninsured patients pursuant to this Policy.

D. Referrals

The Catholic Health System may refer an individual to alternative programs or services within the patient’s community, as long as the referral is medically appropriate, in conformance with all applicable New York State and federal laws such as EMTALA, and places no undue burden on the patient or the patient’s family. The Catholic Health System will assist such patients to locate alternative payment sources for the referred services. Such appropriate referrals will enable CHS facilities to provide the maximum level of necessary healthcare assistance services within the limits of resources.

II. PROCEDURES

A. Healthcare Assistance Notice

1. The Catholic Health System shall provide uninsured patients on admission with written notice of the availability of healthcare assistance, along with instructions on how to apply for such assistance to all uninsured persons who seek services in any of the CHS facilities. The notice shall include the following:

   Patient eligibility for healthcare assistance is determined by assessment of a patient’s ability to pay. This assessment is based on an objective, good faith determination of
HEALTHCARE ASSISTANCE PROGRAM

CATHOLIC HEALTH SYSTEM

financial need, means test that will be applied to all uninsured patients in the same manner and will consider, at a minimum, all income, all income sources, the local cost of living, and family size. Other financial considerations, including, but not limited to other medical care obligations and the extent of the patient’s medical bills, may also be considered. If you think you may be eligible for healthcare assistance and wish to request consideration for such assistance, please contact the Catholic Health System Financial Customer Services Office at 716-601-3607.

B. Eligibility Criteria

1. **Complete Application** - In order to be considered for healthcare assistance, each patient must prepare and submit a complete healthcare assistance application. In order to be considered complete, the application must include the following:
   a. Complete answers to all pertinent and/or applicable questions.
   b. Presentation of acceptable identification, a copy of which must be submitted as part of the application.
   c. Signature and date, in the presence of an acceptable Catholic Health System witness.

2. **Timing of Application for Healthcare Assistance** - whenever possible and practical will be requested prior to the provision of services for all patients that present to a CHS acute care facility without insurance coverage, except when the emergent nature of the healthcare service sought by the patient and the provisions of the Catholic Health System EMTALA Policy require the immediate and prior provision of healthcare service. Application may also be made and will be accepted during or within ninety (90) days after the provision of healthcare services or the date of discharge.
   a. For a variety of reasons some patients may not wish to apply for healthcare assistance prior to the delivery of services, but may decide to do so either during their CHS stay or after completion of services and discharge.
b. There may be cases in which the patient’s need for or awareness of healthcare assistance is not understood by the patient until after the issuance of a bill for service or after an account may have been referred to an outside agency for collection as a bad debt.

c. The patient shall have twenty (20) days within which to complete a application. A complete application shall be one that includes all of the required information, as specified on the application form. Any application that is not complete within the twenty (20) day period, shall be rejected.

3. **Eligible Applicants** – In order to be eligible, the patient applicant must meet the following criteria:
   a. Applicants must be legally responsible for the payment of fees related to services rendered at a CHS acute care facility.
   b. In certain circumstances an individual other than the applicant may apply for an individual who may be an eligible applicant, but who, because of uncontrollable circumstances, is or are unable to complete minimum application requirements. Such an exception must be documented in writing. CHS reserves the right to refuse any request for such an exception.

4. Eligible Recipients of Healthcare Assistance
   a. Any eligible applicant who has received approval is an eligible recipient for healthcare assistance as determined by applicable criteria.
   b. An eligible recipient’s dependents are likewise eligible to receive Healthcare Assistance allowances as determined by criteria that was applicable to the original applicant.

C. **Determination of Eligibility for Healthcare Assistance**

1. **PARO Score™**: PARO™ is a Financial Analysis tool developed and managed by PARO Financial Counseling Solutions that uses up to 200 points of publicly available information to
estimate an individual's need for healthcare assistance. The tool uses the information provided by each individual to develop a PARO Score, which is developed in a manner similar to a FICO score (Fair Isaac Corporation Credit), but is used to evaluate an individual's need for healthcare assistance. CHS will use this score as part of the means test for healthcare assistance.

2. **Income Comparison:** Based on the information provided to CHS an estimated income as a percentage of the Federal Poverty Level (FPL) guidelines issued by the Department of Health and Human Services will be created for each individual. This estimated income as a percentage of the FPL, will also be used as part of the means test for healthcare assistance.

3. **Other Financial Obligations:** Individuals that believe they are eligible for healthcare assistance above that established by the CHS means tests based on the PARO Score™ and Income Comparison methodology noted in II.C.1. and II.C.2. above, may present additional financial information, including but not limited to other medical bills, for further consideration. Please contact the Catholic Health System Customer Service Office at 716-601-3600, to set-up an appointment to review this information.

**D. Determinations Regarding Healthcare Assistance Applications**

1. An application may be granted, denied, or granted in part.

2. An application may be denied based on the following:
   a. The application is incomplete and, despite reasonable efforts on the part of CHS staff to have the application completed, it remains incomplete for a period longer than ninety (90) days after the service is rendered or the date of discharge.
   b. The applicant has made one or more material misstatement of fact on the application.
   c. The applicant does not meet one or more of the eligibility criteria, including but not limited to the financial eligibility threshold.
HEALTHCARE ASSISTANCE PROGRAM
CATHOLIC HEALTH SYSTEM

E. Approval

1. All healthcare assistance application determinations will be made by the criteria established in the CHS Uninsured Expected Payment and Collection Policy, with the exception of cases where other financial obligations are considered. For these cases the CHS Financial Clearance Manager, will adjust the determination as applicable, based on the information provided.

2. An application may be approved to receive 100% healthcare assistance (i.e., total healthcare assistance) or an amount less than 100% healthcare assistance (i.e., less than total healthcare assistance), according to the sliding scale attached hereto as Attachment A.

3. Any applicant approved for healthcare assistance, whether approved for total or less than total healthcare assistance, must resubmit/re-certify his/her application every six (6) months for continued eligibility in the program.

4. Patients may be eligible to use installment plans for the payment of outstanding balances, in accordance with the requirements of New York State law. Any such installment plan will not require payments in excess of 10% of the patient guarantor’s gross monthly income.

F. Notice of Determination

1. Written Notice: Every applicant will receive written notice regarding the determination made by CHS.

2. Notice of the determination of healthcare assistance, including the amount of assistance established will be provided on the first billing statement sent to each individual for each encounter or treatment series.

G. Appeal of Healthcare Assistance Determination

1. Applicants Right to Appeal - An appeal procedure has been established which will cover disagreement and/or objection on the part of the applicant to healthcare assistance denials and/or healthcare assistance approvals which may be for less than the total healthcare assistance. That procedure known as “Appeal of Healthcare Assistance Denial Process”, is as follows:
HEALTHCARE ASSISTANCE PROGRAM

CATHOLIC HEALTH SYSTEM

a. As part of each written notice of determination, applicants will be advised as follows:

If you disagree with, or object to the Catholic Health System decision regarding your application for healthcare assistance, then you may request that the decision be reviewed. A review may be requested in person or via the telephone with the Catholic Health System Financial Clearance Manager. For telephone requests, please contact the Catholic Health System Customer Service Office at 716-601-3600. For in person request, the Catholic Health System Financial Clearance Office is located at:

Apple Tree Business Park, Suite 3550
2875 Union Road
Cheektowaga, NY 14227

Appeal of the determination of healthcare assistance must be submitted within twenty (20) business days of your receipt of the initial statement, which contains the healthcare assistance determination.

If, after reviewing the decision with the Catholic Health System Financial Clearance Manager or other delegated staff members, you are not satisfied, you may request a final appeal of the decision. You will then be entitled to a complete re-evaluation of your application and a written determination of your appeal within thirty (30) days of the date of appeal.

2. Final Appeal Process

a. The Financial Clearance Manager will review all final appeals and note the reason for such appeal. In addition, the Financial Clearance Manager will present such other factors as may be pertinent to the appeal regardless of whether such factors may or may not result in a determination in the favor of the applicant.
b. The Financial Clearance Manager will re-evaluate the application of the appealing applicant in accordance with the requirements of the Catholic Health System program for Healthcare Assistance.

c. The results of that re-evaluation will be communicated to the applicant in writing within thirty (30) days of the date of the appeal or as soon thereafter as is possible.

d. The CHS Chief Financial Officer may request a review of the appeal with or by the CHS facilities Chief Executive Officer in the event of circumstances not explicitly or implicitly covered by the criteria or procedures of the Catholic Health System healthcare assistance Program.

e. A written determination of the final appeal signed by the deciding party or parties will be mailed to the applicant within thirty (30) days of the date of the appeal.

3. Appeal Decision Final

a. With the exception of extraordinary circumstances, such as additional or revised information that would impact the original decision received after the date of the final appeal decision, all decisions rendered on appeals will be final.

b. The written notification of determination of a final appeal will not contain any further notice of right of either further review or appeal.

H. Record Keeping

The Catholic Health System will maintain a log identifying healthcare assistance discounts extended to each individual. All applications and determinations shall be maintained by CHS for a period no less than six (6) years from the date of application.

I. After Insurance Balance Allowances
Individuals applying for After Insurance Balance Allowances must provide a written statement detailing their financial situation. The statement must be signed and dated. In addition, the application must also provide as applicable one of the following:

- Signed copy of their most recent federal tax return
- Copies of their last three pay stubs
- Copies of their last three unemployment payment stubs
- Copies of their last two Social Security Payment Statement
- A signed and notarized statement verifying no income sources

Applications for After Insurance Balance Allowances are subject to the following sections of this policy:

II Procedures

B. Eligibility Criteria

3. Eligible Applicants

F. Notice Determination

G. Appeal of Healthcare Assistance Determination

H. Record Keeping
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<td>90% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>140%</td>
<td>&gt; 29,530</td>
<td>85% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>150%</td>
<td>&gt; 33,270</td>
<td>80% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>160%</td>
<td>&gt; 37,010</td>
<td>75% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>170%</td>
<td>&gt; 40,750</td>
<td>70% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>180%</td>
<td>&gt; 44,490</td>
<td>65% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>190%</td>
<td>&gt; 49,230</td>
<td>60% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>200%</td>
<td>&gt; 54,010</td>
<td>55% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>250%</td>
<td>&gt; 68,780</td>
<td>50% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>300%</td>
<td>&gt; 83,550</td>
<td>45% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>350%</td>
<td>&gt; 98,320</td>
<td>40% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>400%</td>
<td>&gt; 113,090</td>
<td>35% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>450%</td>
<td>&gt; 127,860</td>
<td>30% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>500%</td>
<td>&gt; 142,630</td>
<td>25% of balance after Fixed HAP Discount*</td>
</tr>
<tr>
<td>Over 500%</td>
<td>&gt; 157,400</td>
<td>20% of balance after Fixed HAP Discount*</td>
</tr>
</tbody>
</table>

**Self Pay Discount**

*Fixed HAP Discount*
<table>
<thead>
<tr>
<th>% Federal Poverty Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>HealthCare Assistance Discount</th>
</tr>
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<tbody>
<tr>
<td>Less Than 100%</td>
<td>&gt; 10,830</td>
<td>&gt; 14,570</td>
<td>&gt; 18,310</td>
<td>&gt; 22,050</td>
<td>&gt; 25,790</td>
<td>&gt; 29,530</td>
<td>&gt; 33,270</td>
<td>&gt; 37,010</td>
<td>&gt; 40,750</td>
<td>&gt; 44,490</td>
<td>100% of balance after Fixed HAP Discount</td>
</tr>
<tr>
<td>100%</td>
<td>10,830</td>
<td>14,570</td>
<td>18,310</td>
<td>22,050</td>
<td>25,790</td>
<td>29,530</td>
<td>33,270</td>
<td>37,010</td>
<td>40,750</td>
<td>44,490</td>
<td>100% of balance after Fixed HAP Discount</td>
</tr>
<tr>
<td>110%</td>
<td>11,913</td>
<td>16,027</td>
<td>20,141</td>
<td>24,255</td>
<td>28,369</td>
<td>32,483</td>
<td>36,597</td>
<td>40,711</td>
<td>44,825</td>
<td>48,939</td>
<td>100% of balance after Fixed HAP Discount</td>
</tr>
<tr>
<td>120%</td>
<td>12,996</td>
<td>17,484</td>
<td>21,972</td>
<td>26,460</td>
<td>30,948</td>
<td>35,436</td>
<td>39,924</td>
<td>44,412</td>
<td>48,900</td>
<td>53,388</td>
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</tr>
<tr>
<td>130%</td>
<td>14,079</td>
<td>18,941</td>
<td>23,803</td>
<td>28,665</td>
<td>33,527</td>
<td>38,389</td>
<td>43,251</td>
<td>48,111</td>
<td>53,388</td>
<td>57,837</td>
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</tr>
<tr>
<td>140%</td>
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<td>25,634</td>
<td>30,870</td>
<td>36,106</td>
<td>41,342</td>
<td>46,578</td>
<td>51,814</td>
<td>57,050</td>
<td>62,286</td>
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<tr>
<td>150%</td>
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<td>21,855</td>
<td>27,465</td>
<td>33,075</td>
<td>38,685</td>
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<td>55,515</td>
<td>61,125</td>
<td>66,735</td>
<td>60% of balance after Fixed HAP Discount</td>
</tr>
<tr>
<td>160%</td>
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<td>23,312</td>
<td>29,296</td>
<td>35,280</td>
<td>41,264</td>
<td>47,248</td>
<td>53,232</td>
<td>59,216</td>
<td>65,200</td>
<td>71,184</td>
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</tr>
<tr>
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<td>24,769</td>
<td>31,127</td>
<td>37,485</td>
<td>43,843</td>
<td>50,201</td>
<td>56,559</td>
<td>62,917</td>
<td>69,275</td>
<td>75,633</td>
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</tr>
<tr>
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<td>19,494</td>
<td>26,226</td>
<td>32,958</td>
<td>39,690</td>
<td>46,422</td>
<td>53,154</td>
<td>59,866</td>
<td>66,618</td>
<td>73,350</td>
<td>80,082</td>
<td>30% of balance after Fixed HAP Discount</td>
</tr>
<tr>
<td>190%</td>
<td>20,577</td>
<td>27,683</td>
<td>34,789</td>
<td>41,895</td>
<td>49,001</td>
<td>56,107</td>
<td>63,213</td>
<td>70,319</td>
<td>77,425</td>
<td>84,531</td>
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</tr>
<tr>
<td>200%</td>
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<td>29,140</td>
<td>36,620</td>
<td>44,100</td>
<td>51,580</td>
<td>59,060</td>
<td>66,540</td>
<td>74,020</td>
<td>81,500</td>
<td>88,980</td>
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</tr>
<tr>
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<td>45,775</td>
<td>55,125</td>
<td>64,475</td>
<td>73,825</td>
<td>83,175</td>
<td>92,525</td>
<td>101,875</td>
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<td>54,930</td>
<td>66,150</td>
<td>77,370</td>
<td>88,590</td>
<td>99,810</td>
<td>111,030</td>
<td>122,250</td>
<td>133,470</td>
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</tr>
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<td>75,725</td>
<td>90,065</td>
<td>103,355</td>
<td>116,445</td>
<td>129,535</td>
<td>142,625</td>
<td>155,715</td>
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</tr>
<tr>
<td>400%</td>
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<td>58,280</td>
<td>73,240</td>
<td>88,200</td>
<td>103,160</td>
<td>118,120</td>
<td>133,080</td>
<td>148,040</td>
<td>163,000</td>
<td>177,960</td>
<td>None</td>
</tr>
<tr>
<td>450%</td>
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<td>65,565</td>
<td>82,395</td>
<td>99,225</td>
<td>116,055</td>
<td>132,885</td>
<td>149,715</td>
<td>166,545</td>
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<td>200,205</td>
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</tr>
<tr>
<td>500%</td>
<td>54,150</td>
<td>72,850</td>
<td>91,550</td>
<td>110,250</td>
<td>128,950</td>
<td>147,650</td>
<td>166,350</td>
<td>185,050</td>
<td>203,750</td>
<td>222,450</td>
<td>None</td>
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<tr>
<td>Over 500%</td>
<td>&gt; 54,150</td>
<td>&gt; 72,850</td>
<td>&gt; 91,550</td>
<td>&gt; 110,250</td>
<td>&gt; 128,950</td>
<td>&gt; 147,650</td>
<td>&gt; 166,350</td>
<td>&gt; 185,050</td>
<td>&gt; 203,750</td>
<td>&gt; 222,450</td>
<td>None</td>
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