I. POLICY

NYU Hospitals Center (the "Hospital") strives to provide medically necessary care to patients regardless of their ability to pay. This policy implements the Hospital's financial assistance program (the “Assistance Program”), which is available to New York State residents and individuals, regardless of residency, who receive emergency services and who demonstrate an inability to pay their hospital expenses.

II. FINANCIAL ASSISTANCE

A. Eligibility

Individuals who are New York State residents or receive emergency services at the Hospital who are uninsured, have exhausted their insurance benefits or incur deductibles, copays or coinsurance, which they are unable to pay, are eligible for financial assistance if they meet the criteria described below and in Attachment A, or have been approved for financial assistance by the Senior Vice President & Vice Dean, Chief of Hospital Operations.

B. Covered Services

This Policy covers all medically necessary services at Tisch Hospital, Rusk Institute of Rehabilitation Medicine and NYU Hospital for Joint Diseases, including those set forth below. For purposes of this Policy, medical necessity shall be determined in accordance with Medicare guidelines.

- Inpatient services
- Emergency care
- Clinic services
- Ambulatory surgery
- Referred outpatient services (e.g., services at the Clinical Cancer Center); and
- Ancillary services (such as laboratory services)

This Policy does not cover: cosmetic procedures; bariatric procedures; professional services provided by physicians affiliated with or employed by NYU School of Medicine in their private practice; services by independent contractors (e.g., private duty nurses, home care services, ambulette services); anesthesia services; elective procedures for patients who are enrolled in HMO/commercial insurance plans which do not contract with the Hospital; and discretionary charges such as telephones, televisions and private room differential charges.
C. **General Processing Procedures**

Patients will have at least ninety (90) days from the date of service or discharge to apply for financial assistance. Requests for financial assistance shall be directed to the Financial Counseling Office, which is responsible for:

1. Reviewing with the patient or his/her representative the possible available alternatives (e.g., government sponsored insurance programs, payment arrangements, discounted rates, free care) based on the information provided.

2. If appropriate, completing a Medicaid application or, if the patient is eligible for a government sponsored program (e.g., Family Health Plus or Child Health Plus), referring the patient to the Social Work Department for assistance in applying for the program. Patients who meet the eligibility criteria for a government sponsored insurance program must enroll in and utilize the government program for coverage of the patient's treatment rather than the Hospital's financial assistance program.

3. If appropriate, providing the patient with a financial assistance application and assisting the patient in completing it.

4. Reviewing the financial assistance applications: For Hospital charges under $25,000, a Patient Financial Services (PFS) staff member may approve or deny the application; charges from $25,000 to $50,000 require review by the Senior Director of PFS of the staff member's determination, and charges from $50,000 to $100,000 require the review of the Vice President of PFS. PFS shall forward applications for charges over $100,000, together with its recommendation, to the Charity Care Committee for final determination.

The Financial Counseling Office will notify the patient (by telephone or letter) within thirty (30) days of receipt of the completed application whether the application for financial assistance has been approved or denied. If the application is approved, the patient will be advised of the amount of the reduction and the portion of the bill that he/she is responsible for paying. The Financial Counseling Office will also document the determination of eligibility in the Accounts Receivables management system's notes.

Approval of eligibility for financial assistance is valid for twelve months from the first service date for which the patient submitted a financial assistance application.

D. **Criteria for Determining Eligibility for Financial Assistance**

1. **Criteria for Eligibility**

   Determination of eligibility for financial assistance is based on the following criteria:

   - Patient's residence
   - For non-New York residents, nature of the admission (emergency services, elective, etc.)
• Annual, pre-tax income
• Liquid assets; and
• Family size.

Where the patient has applied for a government sponsored insurance program, the information should be obtained from the application. Patients may self-attest for balances under $2,500 and at the discretion of the Financial Counselor. If any required data is missing, the Hospital will make a minimum of three attempts to contact the patient requesting the missing information; if the patient does not respond the application will be denied. Applying to a government sponsored program for which the Hospital believes the patient is eligible and cooperating with the Hospital in providing complete, truthful information is a condition for determination of eligibility for financial assistance.

2. Income Test

Attachment A to this Policy, "Income Based on Federal Poverty Levels 2009," sets forth the income level at which reduced rates are available, which attachment may be updated from time to time. Income is calculated by comparing the patient's family size with his/her family's annual, pre-tax income.

- **Family Size** is calculated, for adult patients, by adding the patient, the patient's spouse (if any and if he/she resides with the patient) and any dependents of the patient or the patient's spouse, and for minor patients, by adding the patient, the patient's parent/s and/or legal guardian/s with which the patient resides, and any dependents of the patient's parent/s and/or legal guardian/s with which the patient resides (other than the patient).

- **Annual pre-tax income** is determined by adding the following sources of income:
  1. Salary/Wages Before Deductions (if the patient has not filed an application for a government sponsored insurance program or if no such application is available, the patient must provide pay stubs from the previous four weeks, which will be used to extrapolate the patient's salary/wages for the current calendar year).
  2. Public Assistance.
  4. Unemployment and workmen's compensation.
  5. Veteran's benefit.
  7. Other Monetary Support.
  8. Pension Payments.
  9. Insurance or Annuity Payments.
  10. Dividends/Interest.
  11. Rental Income.
  13. Other (strike benefits, training stipends, military family allotments, income from estates and trusts).
For adult patients, the family's annual pre-tax income is the sum of the patient's and patient's spouse's (if any) income. For minor patients, the family's annual pre-tax income is the income of the patient's parent(s) and/or legal guardian(s) with which the patient resides. A pregnant woman is counted as two family members. The calculation of income should only take into account the amounts actually received by the individual rather than amounts to which the individual may be entitled but is not being paid (e.g., patient's ex-spouse fails to pay child support, insurance or pension payments are in dispute). A spouse's income is included in the calculation only if the spouse resides with the patient.

- A Liquid Asset Test will be used in determining eligibility for patients with income up to 150% of Federal Poverty Level (FPL) and over 300% FPL. The Liquid Asset Test is calculated by comparing the amount of liquid assets available against the allowable resource level for Medicaid eligibility published by Human Resources Administration Medical Assistance Program. Patients whose liquid assets exceed the allowable resource level must spend down to the allowable resource level by paying health care expenses. Liquid Assets is the total value of the patient's cash, savings and checking accounts, Certificates of Deposits, equity in real estate and other assets (e.g., Treasury bills, negotiable paper, stocks and bonds), but excluding the value of the primary residence, pension funds/retirement accounts, college savings accounts and cars regularly used by the patients or immediate family members.

E. **Installment Payment Arrangement and Sliding Scale Charges**

Generally, patients will be expected to pay the Hospital's charge at the time service is rendered, but installment plan arrangements may be available for patients who are determined to be eligible for financial assistance. PFS is generally responsible for negotiating the plans, which will not charge interest and which will not provide for monthly payments exceeding ten percent (10%) of the patient's gross monthly income. Installment plans which provide for a payment arrangement longer than twelve months must be approved by the Vice President of PFS.

In addition to installment payment arrangements, sliding scale and additional discounts (e.g., for copayments and deductibles) may be available, on a case-by-case determination based on the particular circumstances.

F. **Appeals**

A patient has the right to appeal to the Charity Care Committee denial of a request for financial assistance or the level of financial assistance approved. The appeals must be made in writing (or in person, by appointment), addressed to the Charity Care Committee, c/o Senior Vice President & Vice Dean, Chief of Hospital Operations, NYU Hospitals Center, 550 First Avenue, HCC-15, New York, New York 10016, within thirty (30) days of notification of the eligibility determination.

Criteria which warrants review by the Charity Care Committee include:
- Incorrect information was provided in the application;
• Changes in the patient's financial status (e.g., recent unemployment which results in the patient's inability to pay for such routine living expenses as rent, utilities and food); or
• Extenuating circumstances (e.g., catastrophic illness).

G. **Financial Assistance Income Eligibility Scoring**

For patients with unpaid balances who do not apply for financial assistance or assist in the application process, the Hospital may submit the patient’s demographics to a credit bureau or utilize credit scoring software for purposes of establishing income eligibility. The scoring will not negatively impact the patient’s FICO.

H. **Fair Billing and Collection Practices**

The Hospital is committed to fair billing and collection practices. Accordingly, the Hospital and/or its employees, representatives, agents and contractors are not permitted to take any of the following actions:

• Send an account to collection while an application for financial assistance (which is complete and with all required documentation) is pending;
• Send an account to collection for a patient who is determined to be eligible for Medicaid at the time services were rendered and for which services Medicaid payment is available; or
• Pursue any action which would cause or prevent the patient from paying his/her normal monthly rent, utility or food expenses.

All collection agents engaged by the Hospital will be required to comply with this policy; seek the Hospital’s written consent prior to instituting a legal action for collection; and advise patients on how to apply for financial assistance. If a lawsuit has been instituted and decided in favor of the Hospital, the Hospital will not seek foreclosure of the patient's primary residence (although it may file a lien) or seek to freeze a patient's bank account or garnish a patient's wages unless expressly authorized by senior administration.

IV. **ACCESS TO INFORMATION**

A. **Distribution of Information**

Patients will be informed of the Hospital’s Charity Care and Financial Assistance Policy by appropriate signage in the registration and intake areas; information distributed in the admission package; and responses to direct inquiries. All Hospital bills and statements will include a statement that if the patient was unable to pay the bill, he or she might be eligible for financial assistance and how to obtain further information. Applications for financial assistance will be available in English, Chinese, Russian and Spanish, and translation services will be made available for patients needing such services.

B. **Staff Training**

All staff involved in registration, admission, insurance verification, financial counseling, billing, collections and customer services will be trained on the appropriate procedure for applying for the financial assistance program.
V. REPORTS

The Hospital will report to the Department of Health the following information:

- Costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other third-party payor coverage;
- the number of patients, organized by zip code, who applied for financial assistance, and the number, by zip code, who were approved and denied;
- The amount of distributions from the Hospital Indigent Care pool;
- The amount spent from charitable funds or bequests established for the purpose of providing financial assistance to eligible patients as defined by such bequests;
- The number of Medicaid applications the Hospital helped patients complete and the number approved and denied;
- The Hospital's gain or loss from providing services under the Medicaid program; and
- If applicable, the number of liens placed on the primary residences of patients through the collection process.

The Hospital will certify its compliance with these requirements through the certification of its outside auditor or through an attestation by a senior Hospital official.

Reference: See 2009 exhibit

ISSUE DATE: June 6, 2006
Updated: January 1, 2010
REVIEWED: 01/10, WS, VP Medical Center Finance