CORTLAND REGIONAL MEDICAL CENTER
POLICY AND PROCEDURE

Department: Credit and Collections     Policy Number: 13-7000-3
Subject: Financial Assistance          Page 1 of 7

Date of Origin: 3/30/90
Date Revised: 4/9/92, 11/23/92, 3/25/93, 11/14/94, 11/14/94, 11/01/00, 11/03, 01/07, 9/11

Recommender(s): [Signature] Business Office Manager

Policy: Cortland Regional Medical Center attempts to give back to the community a reasonable amount of its services without charge or at reduced charges to eligible persons who cannot afford to pay. This policy ensures that Cortland Regional Medical Center is in compliance with all applicable guidelines and that all applications for assistance are processed accurately and in a timely manner.

Procedure:

I. Income Guidelines

1. The Federal Poverty Levels are the guidelines used to determine eligibility. Financial assistance begins with those uninsured patients with incomes below at least three hundred percent of the federal poverty level. These guidelines are updated annually.

2. The decision to provide services free of charge or at reduced levels can be changed within the confines of the law by management.

3. The amount of the financial assistance is determined by the amount that would have been paid for the same services by the highest volume payor of CRMC.

II. Notice to the Public

1. Notices concerning financial assistance for medical expenses incurred at CRMC are visibly posted in all registration areas of the Medical Center.

2. When a patient/guarantor calls with payment concerns, they are informed of the financial assistance program and sent an application.

3. Notice of the financial assistance program is posted on the Medical Center’s website.
Subject: Financial Assistance
Policy Number: 13-7000-03
Page 2

4. Notice of the financial assistance program is indicated on the patients' bills.

III. Terms for Financial Assistance

1. Patients have 90 days to apply for assistance.

2. The completed application accompanied with the required supporting documentation must be returned to CRMC for processing within 20 days of receipt of the application.

3. Once the completed application and required documentation has been received, CRMC has 30 days to process a written approval or written denial.

4. Patients have 20 days from the date of the approval or denial to appeal the determination.

5. Incomplete applications and/or missing documentation can result in a denial. CRMC will attempt to get the missing information after the review of the original application.

6. Any outstanding accounts within 2 years of the date of the application are eligible, unless they are in the process, or have been processed, for a judgment.

7. CRMC will hold the billing for any accounts that are being considered for financial aid. CRMC will inform the patient of such.

IV. Payment Plan

1. For patients with incomes at or below one hundred percent of the federal poverty level, CRMC will not require any payment (nominal amount) for the patient.

2. For patients with incomes between at least one hundred one percent (101) and one hundred fifty percent (150) of the federal level, CRMC shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower incomes shall pay the lowest amount. Such schedule shall provide the amount that CRMC may collect for such patient's increases from the nominal amount described in IV. 1 in equal increments as the income of the patient increases, up to a maximum of twenty percent of the greater of the amount that would have been paid for the same services by the highest volume payor for CRMC or for services provided pursuant to Medicare or Medicaid.
3. For patients with incomes between at least one hundred fifty-one percent and two hundred fifty percent of the federal poverty level, CRMC shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower income will pay the lowest amounts. Such schedule shall provide that the amount CRMC may collect for such patients increases from the twenty percent figure described in IV. 2 in equal increments as the income of the patient increases, up to a maximum of 60% of the greater of the amount that would have been paid for the same services by the highest volume payor for CRMC or for services provided Medicare or Medicaid.

4. For patients with incomes between at least two hundred fifty-one percent and three hundred percent of the federal poverty level, CRMC shall collect no more than the greater of the amount that would have been paid for the services by the highest volume payor for CRMC or for services provided Medicare or Medicaid.

5. For the purposes of this policy, highest volume payor will mean the insurer, corporation or organization licensed, organized or certified pursuant to article thirty-two, forty-two, or forty-three of the insurance law or article forty-four of the public health law, other third party payor which has a contract or agreement to pay claims for services provided by CRMC and incurred the highest volume of claims in the previous calendar year.

6. CRMC will not take into consideration assets owned by a patient, who is a New York State resident, and/or other legally responsible individual, who have annual income at or below 150% of the federal poverty level in determining the patient's potential eligibility for financial assistance as specified in this policy.

7. CRMC provides the use of payment by installment plans. For those patients that receive financial assistance the monthly payment cannot be more than 10% of the patient monthly gross income.

8. If CRMC ever charges interest on the unpaid balances for those accounts under financial assistance program the rate of interest can not exceed the rate of a ninety-day security issued by the United States Department of Treasury plus .5 per cent and a missed payment will never trigger a higher rate of interest.

9. If there is a deposit on a non-emergent, medically-necessary care account it will be included as part of the financial aid consideration.

10. See Chart for application of this section.
11. For patients determined to be eligible for financial assistance, there will be no limitations on financial aid for services based on the medical condition of the applicant, other than typical limitations or exclusions based on medical necessity or the clinical or therapeutic benefit of a procedure or treatment.

V. Required Documentation

1. A copy of the Federal 1040 Income Tax return as verification of dependant status for all household members applying for financial assistance.

2. A copy of the W-2(s).

3. Copies of the last four pay stubs for all working members of the household.

4. Copies of the most recent bank statements.

5. A valid written Medicaid or other public insurance denial is required. A denial is valid for six months from the date of denial.

6. Proof of residency. Acceptable documentation includes, but it not limited to, a postmarked envelope showing current address, a utility bill (gas, electric, cable), rent receipt, etc.

VI. Required Covered Services

1. Emergency services, including emergency transfers.

2. Medically necessary acute care services.

VII. Discretionary Covered Services

1. Residential Care Facility Services

2. Swing Bed Services

VIII. Non-covered Services

1. Medicare coinsurance and deductible amounts

2. Elective surgery (unless medically necessary)

3. Medicaid spend downs and NAMI amounts
IX. General Information

1. This policy applies only to New York State residents. However non-residents will be encouraged to apply for financial aid and each application will be handled on a case-by-case basis.

2. If the applicant is unable to apply in person, one of the following procedures is allowed:

   a) An application is mailed to the patient, completed by him and returned to the financial counselor with appropriate supporting documents as discussed above.

   b) A third party (such as spouse, parent, daughter/son, Power of Attorney, Social Services) completes and signs the application on the patient’s behalf. This is usually done when the patient is a minor or an elderly person who is no longer capable of handling their own affairs.

   c) The information is obtained over the phone and the financial counselor signs the patient’s name and notes that they signed for him. This option should be used as a last resort and only after obtaining the Business Office Manager’s approval.

3. Applications for deceased patients can be processed using the following information:

   a) Eligibility is based on the decedent’s income for the 3 to 12 months prior preceding death.

   b) If the decedent was part of a family household, the family income for the 3 to 12 months preceding the request is utilized. Eligibility is determined using the current household income, regardless of when the patient received services or when they expired.

4. An original completed application and required supporting documentation can be utilized for a period of six months.

5. Any payments made during the application process remain the property of Cortland Regional Medical Center.

6. Payments received from third party payers (ie: Medicare, Medicaid, Commercial Insurance, etc.) after Financial Assistance has been granted, remain the property of Cortland Regional Medical Center.

7. CRMC will not force a sale or foreclosure on a patient’s primary residence in order to collect an outstanding medical bill.
8. CRMC will not forward an account to collection while it is determining the patient's eligibility under the financial assistance policy.

9. CRMC will notify its patients at least 30 days prior to sending an account to collection.

10. CRMC will require its collection agency to obtain written permission on accounts before commencing legal action.

11. CRMC will educate and train all appropriate staff and its collection agency on its financial aid policy.

12. CRMC will not pursue collections from patients who were eligible for medical assistance under the Medicaid program at the time of service.

13. CRMC will submit a report certified by one of its Senior Officials and it will include:
   a) hospital costs incurred and uncollected amounts in providing services to eligible patients without insurance, including the amount of care provided for a nominal amount.
   b) hospital costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other third-party payor coverage.
   c) the number of patients who applied for financial assistance broken down by those that were approved and those that were denied and by zip codes.
   d) reimbursement received for indigent care for the pool established by Department of Health.
   e) the amount of funds that have been expended on charity care from charitable bequests made or trusts established for the purpose of providing financial assistance to patients who are eligible in accordance with the terms or such bequest or trusts.
   f) the number of Medicaid applications the hospital and/or its agent assisted with and the number of approval and denials.
   g) CRMC's financial losses resulting from services provided under Medicaid.
   h) the number of liens placed on primary residences of patients through the collection process used by CRMC.
X. Appeals Process

1. All applicants have a right to appeal the decision made by CRMC.

2. Appeals must be made in writing within 20 days from the date of approval or denial.

3. A final determination will be made within 20 days of the date of the appeal.

Forward appeals to:
Cortland Regional Medical Center
Vice President Finance/CFO
134 Homer Ave.
Cortland, New York 13045

Cross Reference to Code
JCAHO:
NYSDOH:
MEDICARE CONDITIONS OF PARTICIPATION
## 2011 Poverty Guidelines
**All states except Alaska, Hawaii and D.C.**

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<th>185 Percent Of Poverty</th>
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**For families with more than 8 persons, add $3,820 for each additional person**
Cortland Regional Medical Center  
P.O. Box 2060  
Cortland, NY 13045  
(607) 756-3530

[DATE]

[GUARANTOR NAME]  
[GUARANTOR ADDRESS LINE]  
[GUARANTOR CITY, STATE ZIP]

RE: Account [ACCOUNT #]  
Financial Assistance Request

Dear [GUARANTOR NAME],

Enclosed you will find a Financial Assistance Application and a list of information needed in order to process your application. Please send the completed application and required documentation within 20 days to:

Cortland Regional Medical Center  
P.O. Box 2060  
Cortland, NY 13045  
Attn: Financial Counselors

Please be aware that applications cannot be processed without all the necessary information and supporting documentation. Should you have any questions, or need assistance with this process, please call the Business Office at (607) 756-3530.

Sincerely,

Business Office
APPLICATION FOR FINANCIAL ASSISTANCE  [DATE]

If you have questions or need assistance with this application, please call the Business Office at (607) 756-3530.

Please provide the requested information for everyone claimed as a dependent on your Federal 1040 Income Tax Return. Be sure to include yourself and your spouse if applicable.

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I certify that the information on, and supplied with, this application is true and accurate to the best of my knowledge. Further, I agree to cooperate with efforts to secure Medicaid or other public insurance coverage.

I understand that this application is made so that Cortland Regional Medical Center can determine eligibility for Financial Assistance under its Financial Assistance Policy. If any information I have given proves to be untrue, I understand the Medical Center may re-evaluate my financial status and take appropriate action.

Applicant’s Signature: __________________________

Date of Request: ___/___/___

REQUIRED DOCUMENTATION [DATE]

The following is a list of required documentation needed to process your application for Financial Assistance:

* A copy of the Federal 1040 Income Tax Return as verification of dependent status for all household members applying for financial assistance.

* A copy of the W-2(s).

* Copies of the last four pay stubs for all working members of the household.

* Copies of the most recent bank statements.

* A valid written Medicaid or other public insurance denial is required. A denial is valid for six months from the date of denial.
* Proof of residency. Acceptable documentation includes, but is not limited to, a postmarked envelope showing current home address, a driver's license issued within the last six months, a utility bill (gas, electric, cable), a rent or mortgage receipt showing the current home address, etc.

Failure to provide any of this information will result in the denial of your application.