FAXTON- ST. LUKE'S HEALTHCARE
UTICA, NEW YORK

Administrative Manual

New: 
Last Review: 9/1/2009
Effective Date: 6/24/2002

Directive: FN-14-OP
Subject: Uncompensated Care Program

Administrative Approval: 
[Signatures]
President/CEO
Senior Vice President/COO
Senior Vice President/CFO

POLICY:

Faxton-St. Luke's Healthcare complies with Regulation 312-D of the HCFA Manual and provides an Uncompensated Care Program for those individuals who cannot pay for needed healthcare services.

PURPOSE:

To provide services to patients who are uninsured or unable to commit to a financial agreement. This policy does not apply to those patients who seek elective services or procedures such as elective cosmetic surgery, elective dental surgery, meals on wheels, lifeline services, hearing aids, or therapies outside the scope of physician's orders.

SCOPE:

Organization-wide

REPLACES:

SPECIAL INSTRUCTIONS:

According to Regulation 312-D of the HCFA manual, the hospitals/clinics must investigate the financial situation of patients who request the uncompensated care program.

PROCEDURE:

1. A patient or guarantor requesting uncompensated care may be asked to apply for Medicaid. Patient/Guarantor will have up to ninety days from service date to apply for financial assistance. The following information must be provided with the application to aid in the decision by the hospital to provide free care.

   ➢ A copy of the latest year of tax filing.
   
   ➢ A completed uncompensated care application, which is provided by the hospital must be completed in its entirety within thirty days of receipt of the application.
   
   ➢ Proof of income information, we must consider bank accounts, pension checks and insurance policies. As the law states “only those assets convertible to cash and unnecessary for the patient’s daily living”.

2. The calculation of eligibility may include some or all of the following sources:
   All Assets
   Excess Amount
   Spend down Amount
   Bank Accounts
   Pension Accounts
   Insurance Policies

   Plus Income

   Equals Guideline Amount

The guideline amount is compared to (3X) the Federal poverty guideline. The Federal poverty guideline can be obtained at:
   http://ASPE.HHS.GOV/POVERTY>SHTML.

3. The patient is notified with a decision whether approved or denied by the Credit Manager within fourteen business days of receipt of an application.
4. If the patient is approved the account is written off to charity/bad debt. If the patient has Medicare for insurance, the hospital will process as a Medicare charity/bad debt write off.

5. Further internal requirements for Medicare write off must include a CODR (create on demand bill) and Medicare EOB (explanation of benefits), which accompanies each Medicare account that is being considered for a write off.

6. An agency activity report is utilized to report any Medicare recoveries.

<table>
<thead>
<tr>
<th>SIZE OF FAMILY</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$ 32,490.00</td>
</tr>
<tr>
<td>2</td>
<td>43,710.00</td>
</tr>
<tr>
<td>3</td>
<td>54,930.00</td>
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<td>5</td>
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<tr>
<td>6</td>
<td>88,590.00</td>
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<tr>
<td>7</td>
<td>99,810.00</td>
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<tr>
<td>8</td>
<td>111,030.00</td>
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FOR FAMILY UNITS WITH MORE THAN EIGHT MEMBERS ADD $ 3,740 FOR EACH ADDITIONAL MEMBER.