LEV\ES COUNTY GENERAL HOSPITAL
LOWVILLE, NY

PATIENT ACCOUNTING

SUBJECT: PATIENT FINANCIAL ASSISTANCE (CHARITY CARE) PROGRAM

Effective Date: January 1, 2007

Approved By: ______________________

POLICY

It is the policy of Lewis County General Hospital to provide patient financial assistance for individuals who demonstrate that the cost of our services will create a financial hardship. Patient financial assistance is available for all services provided by Lewis County General Hospital and Hospital employed physicians. Eligible patients include all patients, regardless of race, religion, creed or national origin. Eligibility will be based upon the individual's income compared to existing federal poverty guidelines. This will be determined from the information provided on the financial assistance application. This information is combined with their eligibility for Medicaid and any other entitlement program to determine any financial assistance awarded. Patient financial assistance is available for financially eligible residents of Herkimer, Jefferson, Lewis, Oneida, and Saint Lawrence counties and is voluntarily extended to all residents of New York State. Residential Health Care services and the sale of hearing aids are excluded from this program.

PROCEDURE

General Information:

All information is considered strictly confidential. Applications should be stored in a "locked" file cabinet and be accessible only by the financial counselors within the Credit & Collections department along with the Patient Accounts Manager, and the Chief Financial Officer.

Staff Involved:

Registration Personnel:
- Distribute hospital financial policy along with information about financial assistance eligibility
- Refer those patients who appear to have a need for financial assistance to the Credit & Collections Department

Facilitated Enroller:
- Performs interview, collects information, completes Medicaid application and submits application to county Social Services department

Credit & Collections Department
- Provides charity care application to the patients.
- Assists patients with the completion of the application as necessary or upon request.
- Reviews the completed application along with the corresponding accounts to:
  1. Determine that all available insurance and entitlements have been identified and used.
  2. Applies indigency criteria (as defined by the attached policy and principle statement) in conjunction with the federal income poverty guidelines to determine if applicants meet the need criteria.
- Forwards charity care application with recommendation for review and final approvals.
- Notifies patients by letter of final decisions within 5 business days of decision.
- Process approved applications for charity care by applying the appropriate credits to the patient’s accounts.

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- Maintains monthly ledger of total financial assistance awards.
- Upon receipt of denied applications, contacts the individual responsible to arrange payment of the account.

Patient Account Manager/Supervisor
- Either approves or denies the charity care recommendation, noting the reasons, for the denials.
- Forwards approved applications to the Chief Financial Officer.
- Forwards denied applications to the Chief Financial Officer.

Chief Financial Officer
- Approves or denies charity care recommendation.
- Forwards both approved and denied charity care applications to Credit & Collections.

SIGNATURE AUTHORITY LIMITS FOR CHARITY CARE APPROVAL
All approvals require the signature of the Patient Account Manager and the Chief Financial Officer.

INDIGENCE CRITERIA

While flexibility in applying guidelines to an individual patient’s financial situation is clearly needed, objective criteria are essential for consistent and reliable accounting treatment of charity care services and bad debts.

Evaluation of the appropriate criteria in determining whether a patient is eligible for financial assistance must be ongoing. This review is necessary for the hospital to properly identify the extent of resources devoted to such services and at the same time exercise good stewardship in expending hospital resources. If criteria are narrow and restrictive, the goal of objective and consistent determination may be achieved at the individual patient’s expense. If criteria are too broad and general the classifications...bad debts or charity services becomes highly subjective and the possibility of misclassification increases.

Flexible guidelines have been established which allow the hospital to exercise a reasonable degree of latitude in establishing eligibility for financial assistance. The guidelines include criteria for evaluating future as well as current ability to pay. In order to assure objectivity and consistent implementation of the financial assistance guidelines which are established, the hospital will periodically review samples of patient accounts which have failed to meet determinations criteria as well as those which have been accepted for financial assistance.

In determining financial assistance eligibility, the hospital will consider the following guidelines and factors:

a. Gross income will fall within established or recognized standards for determinations of poverty level, considering family size, and other pertinent factors. As a general rule, patient’s gross income must not exceed 300% of the existing federal poverty guidelines. 100% reduction in account will be given when income is at or below federal poverty guidelines – patient responsibility increases as income exceeds the federal poverty guidelines as indicated below:
   1. 25%-30% poverty guidelines – liability not to exceed reimbursement provided by major insurance companies
   2. 151%-230% poverty guidelines – discount percentage based on sliding scale from 80% discount to 20% discount.
   3. 101%-150% poverty guidelines – discount percentage from 10% to 20% discount.
   4. 100% poverty guidelines and lower – discounted in full.

b. Gross income will be determined using the most current information available such as, pay stubs, social security statements, unemployment or disability information, etc. Current employment status will also be evaluated along with future earnings capacity. Such documentation must pertain directly to the applicant’s current income. For example, copies of state of federal tax returns are not required since they do not directly address current income. In addition, information regarding the applicant’s monthly bills and other expenses are not required for the purpose of determining income.

c. Eligibility must be established at minimum, on a twelve month interval, or as the applicant’s financial

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circumstances change. A period of less than twelve months will require only a signed re-certification form along with copies of the most recent sources of income (pay stubs, social security statements, etc.). Current tax returns are not required.

APPLICATION PROCESS/ELIGIBILITY DETERMINATION

1. Patients requesting financial assistance must provide Lewis County General Hospital with all requested documents identifying household income.

2. An "Application for Financial Assistance" must be completed by the patient. The patient must be allowed at least 90 days to submit an application for financial assistance from the date that services were performed. Additionally, the patient must be given at least 20 days from the receipt of the financial assistance application, for a total of 110 days, to submit the financial assistance application to the hospital.

3. Patients must allow income to be screened by contracted Facility Enroller or county Department of Social Services to determine eligibility for NYS sponsored programs – Family Health Plus, Child Health Plus, and Medicaid. Failure to allow income to be screened and participate in these programs, if eligible, could disqualify applicant from further financial assistance. However, the denial of benefits from NYS sponsored programs or Medicaid is not a pre-condition for applying for financial assistance.

4. Patients must initiate the financial assistance process prior to the time of collection referral.

5. The hospital cannot refer an account to collection while a financial assistance application is pending.

6. The first step in the process shall consist of contacting either the contracted Facility Enroller or the county Department of Social Services and completing a Medicaid application. Once the initial step is completed patients will have a maximum of 30 days to provide all required documentation needed to finalize the Medicaid eligibility assessment.

7. A final decision of financial assistance eligibility will occur within 30 days of receipt of all necessary documentation. That documentation must include - proof of income, and Medicaid/Family Health Plus, etc. eligibility assessment.

8. Once a decision is made, a formal letter will be sent to the patient/guarantor within 5 days of decision. The letter will contain description of the decision. If denied, the specific reason for denial, including the income qualifications, etc. along with identifying the appeal process. If a partial discount is approved the letter will identify the income used to determine the discount percentage along with identifying the amount still due.

9. Appeals must be initiated within 30 days after notification of decision.

10. Residential Health Care services and the sale of hearing aids are not eligible for financial assistance.