Statement of Purpose
The Mount Sinai Hospital of Queens ("The Hospital") recognizes that many of the patients it serves may be unable to access quality health care services without financial assistance. The Mount Sinai Hospital of Queens Financial Assistance Policy ("the Policy") was developed to ensure that The Hospital continues to uphold its mission of providing quality health care to the community while carefully taking into consideration the ability of the patient to pay, as applied in a fair and consistent manner.

Policy
Prior to or at the time of service; all patients of The Hospital will have access to information regarding assistance for paying estimated or actual charges for Hospital services. Patients will be provided assistance in applying for public insurance or government or Hospital Financial Assistance programs based on financial need and eligibility for such. All Patients are presumptively eligible to apply for assistance. Applications for assistance should be filed within 90 days of discharge or point of service.

Patient Eligibility:
- Patients are considered eligible to qualify under the Policy if:

  Emergency Admissions:
  - their primary residence is in the State of New York, and
  - they meet all financial requirements; and
  - they are uninsured, have exhausted or will exhaust all available insurance benefits.

  Medically Necessary Non Emergency Admissions:
  - their primary residence located in the City of New York or Nassau County and
  - they meet all financial requirements; and
  - they are uninsured, have exhausted or will exhaust all available insurance benefits.

- Patients are considered ineligible to qualify under the Policy if:
  - False information was provided by the patient or responsible party; or
  - The patient or responsible party refuses to cooperate with any of the terms of this policy; or
o The patient or responsible party refuses to apply for government insurance programs after it is determined that the patient or responsible party is likely to be eligible for those programs.

o The patient or responsible party refuses to adhere to their primary insurance requirements.

- Patients may appeal a determination of ineligibility or unfavorable discount rate

**Eligible Services:**

- All hospital charges that are medically necessary including:
  - Inpatient services
  - Ambulatory surgery
  - Emergency care
  - Outpatient services including clinic

- In cases of dispute of medical necessity, the Utilization Review Department or The Hospital’s Chief Medical Officer will make the final determination of medical necessity.

**Non-Eligible Services:**

- Services provided that are not medically necessary (i.e. cosmetic surgery)

- Physician fees are not covered by this policy, except for staff physicians

- Discretionary charges such as private room, private nurse, phone, TV, etc.

**Policies and Procedures:**

Administration of this policy will be through Patient Financial Services (“PFS”) and/or the Financial Assistance Office (“FAO”).

**Eligibility Determination:**

- PFS/FAO will determine if a patient has third party coverage (If coverage is determined, the treatment and plan of care must be covered and provided under any available third party coverage);

- If no third party coverage exists, PFS/FAO will determine if the patient is eligible for government insurance programs;

- The applicant has 30 days in which to complete the application documentation process.
• In the event that the patient is fully eligible for Medicaid under the "Emergency Services Only" coverage or, be fully eligible for Medicaid; AND the services are not billable to the Medicaid program for payment (nor excluded under the policy), the applicant should be automatically deemed eligible for Charity Care under Level 1 of the program or, if employed, the appropriate discount level. No further documentation will be required other than confirmation from the State of New York via the institutional billing system (PATCOM). Such determination for Charity Care will be for the specific date of service to which the visit(s) occurred and were not certified to meet the definition of an emergency as described on the DSS-2151 or the current New York State Certification of Emergency treatment form in use at the time in which the services were rendered.

• If approved under the policy, such eligibility period should not exceed one year commencing on the first of the month of which services were first delivered, if the patient requires an ambulatory surgery procedure or inpatient hospitalization, they MAY BE required to recertify eligibility under the program. At the end of the eligibility period, patient will be required to recertify under the policy in effect at the time of the current application;

• If the patient is ineligible for government insurance programs and if PFS/FAQ agrees with such determination, the Policy and associated payment options should be explained to the patient and an application should be completed by the patient or responsible party;

• Patients must provide the following documentation with the Policy application (documentation must meet the standards of proof applied by Medicaid to Medicaid application documentation):
  o Proof of address;
  o Proof of Identity;
  o Current financial management as evidenced by income verification (wages, disability benefits, comp, etc) by providing:
    ▪ 30 days of the most recent payroll stubs; or
    ▪ Employer letter; or
    ▪ most current Federal Tax returns with all schedules; AND/OR
    ▪ Letter from the Social Security Administration or the New York State Department of Labor regarding unemployment benefits; AND/OR
    ▪ Letter of support from individuals providing for patient’s basic living needs;
  o Proof of dependents (if claimed);
  o Proof of child support, alimony (if claimed); and
o Proofs of assets are not required to determine actual discount under the policy.

- As allowed in Medicaid documentation standards, self attestation (Form MAP 2050a) may be accepted if the above is not obtainable.

- Eligibility for Financial Assistance is determined based on family size and income:
  o For all covered services under the Policy, PFS/FAO will apply a means test and sliding fee scale based on gross income and family size. (See attached “Sliding Fee Scale Discount Table Inpatient Services”).
  o The sliding fee income guidelines will be adjusted to remain consistent with Federal Poverty Level updates;
  o The Sliding Fee Table may be further revised by Mount Sinai Hospital of Queens in accordance with New York State statute.

- As determined by each area, the PFS and FAO will each assign a departmental designee that will review each application and make a final determination on Charity Care eligibility and payment agreements (if required under the policy);

- PFS/FAO staff shall render decisions to determine eligibility for Charity Care within 30 days of receipt of a completed application (including all required supporting documentation);

- Patients who receive additional services beyond the originally agreed upon services shall remain financially liable for the additional services and such modification may result in a re-evaluation of the patient’s eligibility under this policy or any other government sponsored programs available.

- Mount Sinai Hospital of Queens reserves the right to evaluate any patient’s eligibility on a case-by-case basis, especially where complex medical, scientific or financial situations exist;

**Deposits:**
Any deposit paid as part of this program will be included in the overall discount package.

**Payment Determination:**
- Where PFS/FAO has found a patient eligible for Charity Care, an appropriate discount will be determined based on the Sliding Fee Scale Discount Table;
- The patient or responsible party will be notified in writing of eligibility and if eligible and if applicable, asked to sign a payment agreement;
- A New York State surcharge will be added to all amounts determined to be the patient’s responsibility, as appropriate under the Health Care Reform Act;
• Payment terms shall be compliant with the existing the New York State Financial Assistance Law. Payment terms shall not exceed the limits as set forth under the law and shall not include interest (all installment plans are interest free).
  o Installment plans (if any) shall not exceed 10% of the head of household gross monthly income in accordance with New York State Statute.

Appeal of Eligibility Determination:
• A patient has the right to appeal decisions on eligibility for Charity Care within 30 days of notification of non-eligibility;
• Appeals can only be submitted based on the following:
  o Incorrect information was provided; OR
  o A change in the patient’s financial status occurred; OR
  o Due to extenuating circumstances;
• The Director of the PFS will decide appeals in cases as specified above.
• Appeals should be made in writing (or in person, only by appointment) to the Director of the PFS at the following address:
  Mount Sinai Hospital of Queens
  25-10 30th Avenue
  New York, N.Y. 11102
  Attn: Dale Weaver, Director Patient Financial Services

• The PFS Director will make reasonable efforts to issue an appeal decisions within 10 business days of receipt of a patient appeal (i.e., after receipt of letter or an in-person appeal)
• The PFS Director, at its discretion, may request that an application or additional appeal be filed for Government sponsored benefits as part of the Charity Care appeal process;

Follow-Up Information:
• Patients are responsible for promptly reporting changes in financial status and/or contact information to the PFS;
• If a patient or responsible party is unable to comply with a signed payment agreement they must contact PFS;
• If a patient or responsible party defaults on a financial agreement with The Hospital, the account in question will be considered delinquent and the Hospital reserves the right to refer patient accounts to an outside collection service, where
appropriate, consistent with guidelines set forth in The Mount Sinai Hospital of Queens Collections Policy and by law.

Communication and Training:
- Patients obtain information on hospital charges and eligibility for government or hospital programs (including the Policy) primarily from:
  - PFS/FAO;
  - the Outpatient Registration Department;
  - multi-lingual signage or brochures at points of patient service (Including but not limited to, intake and registration areas);
  - information distributed in the admission package;
  - referral to FAO by the patient service area;
  - responses to direct inquiries made to Mount Sinai Hospital of Queens;
  - bills sent to all patients that have a Self-Pay balance which will include information on who to contact if the patient believes they will have difficulty in paying the balance due.
- All patients will be provided charge information for specific procedures as requested.
- PFS will provide estimates on total charges with the cooperation of the patient's physician. In the absence of input from the patient's physician, PFS will supply standard hospital charge (full charge rates) information to patients in addition to information regarding this Policy. Once the appropriate discount level has been determined, the bill will be adjusted down to the appropriate charge;
- For services rendered to diagnose or treat an emergency medical condition:
  - appropriate medical screening and stabilization services will be completed before a Financial Counselor seeks information concerning sources of payment;
  - Neither a Financial Counselor nor PFS/FAO staff shall take any action that might inhibit The Hospital’s compliance with its obligations under the Emergency Medical Treatment and Labor Act (“EMTALA”) and hospital policies on compliance with EMTALA;
  - Emergency Department services will be billed at full charges with information about whom to contact if the patient believes they will have difficulty in paying the balance due.
  - PFS/FAO will assure that all staff responsible (i.e Financial Counseling, Customer Service) to engage or otherwise assist on the application of services
covered under this policy are trained on the Financial Assistance Policy and subsequent revisions thereof.

Collection Agencies:
Collection agencies are instructed that they must follow the principles as outlined in the Policy and as are prudent, based on a patient’s or responsible party’s financial history and current financial situation. Certain legal actions (e.g. liens or garnishments) will only be approved in cases where the PFS determines that a patient has the means to pay outstanding balances. For all legal actions, the collection agency must present documentation to the PFS supporting such action.

- At no time will Mount Sinai Hospital of Queens force the sale of a primary residence in order to settle a debt.
- No account will be placed with an Agency to collect on a debt so long as the application for assistance is in process.
- Unless otherwise prohibited, no account will be referred to an agency without 30 days written notice.
- All persons granted financial assistance will have 30 days after the final notice under this policy to either pay or dispute the debt before it can be turned over to an agency.
- Except as defined under the statute, any patient that is eligible for Medicaid shall not be referred to an Agency for collections.
- Collection agencies shall provide information on how to apply for financial assistance when appropriate.

Policy Administration & Maintenance:
The PFS and FAO will centralize the reporting of the data for decisions rendered under this policy and document such in the Hospital’s accounting system. Such centralization will be limited only to decisions rendered under the terms of this policy for the purposes stated below as well as compliance with the New York State Financial Assistance Law. The PFS will collect and distribute information to The Hospital’s management team and Board of Trustees regarding its Charity Care Policy. This policy and the activities herein are subject to internal audits.