NICHOLAS H. NOYES MEMORIAL HOSPITAL
REVENUE CYCLE POLICIES

SUBJECT: Financial Assistance Program

POLICY #: PFS-17

EFFECTIVE DATE: 3/02

ISSUED BY: Revenue Cycle

PURPOSE: To assist low-income, uninsured individuals who cannot afford to pay the full amount of their care. In addition, to direct patients to get free or low-cost health insurance or arrange a manageable payment plan according to the Contract Policy RC.COLL.3.

POLICY: Financial Assistance will be available to qualified patients who fall at or below 300% of the Federal Poverty Level. In support of Nicholas H. Noyes Memorial Hospital’s Mission, Vision and Values the following goals will be the foundation to the Financial Assistance Program.

1. Provide necessary medical care to all patients regardless of their ability to pay.
2. Assist the low-income, and uninsured that are willing but unable to pay in full for medically necessary care.
3. Attempt to educate patients through:
   * Social Work and financial counseling efforts, about their potential financial obligation as well as their responsibility to obtain available insurance, understand the collection practices and Financial Assistance program.
   * Financial Assistance Summary handouts.
   * Posters posted in all public areas.
   * A message and telephone number about the financial assistance on all Self Pay bills.
4. Establish a program that provides needed assistance but is not a substitute for employer-sponsored, public or individually purchased insurance. Nor is it a substitute for the responsibility of government to find solutions to the uninsured and underinsured.
5. Administer the program fairly, so the customer can easily understand the program. The requirements will be respectful, confidential and consistent.
6. Translation services will be available as needed.
7. Assets will not be used in determining the discount.

PROCEDURES:

Hospital, Livingston Health Services (LHS), Genesee Regional Orthopaedics, & Mental Health (for Emergency Room, Noyes First Steps, and Diabetes Center of Excellence, see below)

1. A brochure and Financial Assistance Summary is passed out at time of service to all uninsured outpatients and each patient is asked if he/she would like a call from a Financial Counselor to help further explain the Financial Assistance Program and the other low-cost insurance options.
2. The hospital Social Worker will educate the uninsured inpatient about the Financial Assistance Program and all options for insurance.
3. All uninsured patients will receive a 10% discount at time of billing and a 20% prompt pay discount if payment or arrangement for payment is made within 31 days.
4. Any patients in need of financial assistance will be directed to the Collection Department. Patients have 90 days from the date of their first bill to contact the Collection Department for assistance. If found indigent, the patient’s initial 10% discount will be included in the patient’s financial assistance discount.
5. Affordable payment arrangements can be made for patients who cannot afford to pay balances left after partial discounts per the Contract Policy RC.COLL.3.
6. Any patient applying for financial assistance may have to apply for Medical Assistance and provide denial letter to the Collection staff (See Special Circumstances below).

7. The guarantor must provide the number of people in household, the monthly income and proof of income within 20 days of requesting financial assistance or financial assistance may be denied. No collection efforts will take place during the 20 day application period.

8. Acceptable proof of income is Medical Assistance denial documentation and/or the last 4 weeks of pay stubs, if employed. The last tax return is acceptable proof of income for the self-employed.

9. Upon receipt of the financial assistance application and supporting documents, a determination for financial assistance will be made and communicated to the patient within 30 days and is valid for one year.

For the sliding scales, the family unit is to the left and the percent of discount is above each income level. The household income must be at or below the income listed for the family unit size for the applicable discount and the bill will be reduced accordingly:

<table>
<thead>
<tr>
<th>100% or less of poverty level</th>
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<tbody>
<tr>
<td>Size of Family Unit</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
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<td>7</td>
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<td>8</td>
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</tbody>
</table>

For each additional person, add 3,740

A minimum of $10 per account applies to the below discounts.

<table>
<thead>
<tr>
<th>Income at 101% to 150% of the poverty level</th>
</tr>
</thead>
<tbody>
<tr>
<td>96%</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
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151 - 200%

| 91% | 89% | 87% | 85% | 83% |
| 1 | $17,328 | $18,411 | $19,494 | $20,577 | $21,660 |
| 2 | $23,312 | $24,769 | $26,226 | $27,683 | $29,140 |
| 3 | $29,296 | $31,127 | $32,958 | $34,789 | $36,620 |
| 4 | $35,280 | $37,485 | $39,690 | $41,895 | $44,100 |
| 5 | $41,264 | $43,843 | $46,422 | $49,001 | $51,580 |
| 6 | $47,248 | $50,201 | $53,154 | $56,107 | $59,060 |
| 7 | $53,232 | $56,559 | $59,886 | $63,213 | $66,540 |
| 8 | $59,216 | $62,917 | $66,618 | $70,319 | $74,020 |

201 - 250%

| 81% | 79% | 76% | 73% | 70% |
| 1 | $22,743 | $23,826 | $24,909 | $25,992 | $27,075 |
| 2 | $30,597 | $32,054 | $33,511 | $34,968 | $36,425 |
| 3 | $38,451 | $40,282 | $42,113 | $43,944 | $45,775 |
4  $46,305 $48,510 $50,715 $52,920 $55,125
5  $54,159 $56,738 $59,317 $61,896 $64,475
6  $62,013 $64,966 $67,919 $70,872 $73,825
7  $69,867 $73,194 $76,521 $79,848 $83,175
8  $77,721 $81,422 $85,123 $88,824 $92,525

251 - 300%

67%  64%  61%  58%  55%
1  $28,158 $29,241 $30,324 $31,407 $32,490
2  $37,882 $39,339 $40,796 $42,253 $43,710
3  $47,606 $49,437 $51,268 $53,099 $54,930
4  $57,330 $59,535 $61,740 $63,945 $66,150
5  $67,054 $69,633 $72,212 $74,791 $77,370
6  $76,778 $79,731 $82,684 $85,637 $88,590
7  $86,502 $89,829 $93,156 $96,483 $99,810
8  $96,226 $99,927 $103,628 $107,329 $111,030

EMERGENCY ROOM

1. A brochure and Financial Assistance Summary is passed out at time of service to all uninsured outpatients and each patient is asked if he/she would like a call from a Financial Counselor to help explain the Financial Assistance Program and the other low-cost insurance options.

2. During the registration process, income information and the number of people in the household is obtained and recorded for preliminary financial assistance determination and any patient falling at or below 300% of the poverty level upon screening will be given an estimated discount amount to be finalized upon proof of income. Follow up will be performed by a Financial Counselor to assist with the financial assistance application process.

3. All uninsured patients will receive a 10% discount at time of billing and a 20% prompt pay discount if payment or arrangement for payment is made within 31 days.

4. Any patients in need of financial assistance will be directed to the Collection Department. Patients have 90 days from the date of their first bill to contact the Collection Department for assistance. If found indigent, the patient’s initial 10% discount will be included in the patient’s financial assistance discount.

5. Affordable payment arrangements can be made for patients who cannot afford to pay balances left after partial discounts per the Contract Policy RC.COLL.3.

6. Any patient applying for financial assistance may have to apply for Medical Assistance and provide denial letter to the Collection staff (See Special Circumstances below).

7. The guarantor must provide the number of people in household, the monthly income and proof of income within 20 days of requesting financial assistance or financial assistance may be denied. No collection efforts will take place during the 20 day application period.

8. Acceptable proof of income is Medical Assistance denial documentation and/or the last 4 weeks of pay stubs, if employed. The last tax return is acceptable proof of income for the self-employed. If no proof is available, the initial income given may be used for determination.

9. Upon receipt of the financial assistance application and supporting documents, a determination for financial assistance will be made and communicated to the patient within 30 days and is valid for one year.

NOYES FIRST STEPS

All First Steps patients are at or below the 300% federal poverty level and therefore will automatically qualify for the Financial Assistance Program and will receive a full discount when denied or not applying for Medical Assistance.
DIABETES CENTER OF EXCELLENCE

1. The Diabetes educators will inform the guarantor of the financial assistance program for diabetes education when scheduling their appointment.
2. All uninsured patients will receive a 10% discount at time of billing and another 20% prompt pay discount if payment or arrangement for payment is made within 31 days.
3. Any patient in need of financial assistance will be directed to the Collection department. Patients have 90 days from the date of their first bill to contact the Collection department for assistance. If found indigent, the patient’s initial 10% discount will be included in the patient’s financial assistance discount.
4. All Medicaid patients must sign a Medicaid waiver letter, complete the financial assistance application and provide proof of income within 20 days.
5. Any patient applying for financial assistance may have to apply for Medical Assistance and provide denial letter to the Collection department (See Special Circumstances). A financial assistance application must be completed and proof of income provided within 20 days.
6. Once information is received in the collection department, the bill will be adjusted to financial assistance according to the above levels.

SPECIAL CIRCUMSTANCES:

Patients may not be required to apply for Medical Assistance if:
1. The Social Work or Collection Department determines the patient is single with no dependents and income is above the Medical Assistance guidelines and the patient received only outpatient services.
2. The patient has been denied Medical Assistance in the past and the monthly income has increased.
3. The patient’s religion prohibits participation in government health programs (Amish).
4. The patient’s citizenship status prohibits disclosing personal and financial information.

Catastrophic Events:
1. Patients whose income exceeds 300% of the poverty levels but incurred medical bills over 20% of the annual household income will be granted catastrophic financial assistance.
2. The patient will not be required to pay over 20% of their annual household gross income.
3. All NMH medical bills related to the catastrophic event will be combined for the one time discount.

Deceased Patient Accounts:
Deceased patients’ accounts with no estates will be considered indigent and adjusted to charity care.

Based on unique circumstances the committee may use their discretion to adjust financial assistance.

APPEALS:

A patient may appeal a financial assistance determination by contacting the Collection Department Team Leader within 14 days. The appeal will be reviewed by the Financial Assistance Team and a final determination made and communicated to the patient within 30 days.
REPORTING:

Charity Care will be reported quarterly to the Financial Assistance Committee.

Originated: 3/18/02
Revised: 12/24/02, 06/01/03, 5/1/04, 9/8/04, 10/14/04, 6/2/05, 12/5/05, 8/18/06, 12/1/06, 2/01/07, 3/15/08, 2/24/09
Committee Approval: Financial Assistance Committee 9/16/05, 12/1/06

Signature: Amy Earner ___________________________ Title: Revenue Cycle Coordinator
[DATE]

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

Dear [GUARANTOR NAME]:

Per our conversation, I have attached a financial assistance application for your completion.

Please be sure ALL questions are complete, you have attached your check stubs, signed the application and return it to me within 30 days.

It is important to return this within the 30 day period. If it is not returned your account could be sent to our collection agency.

If you have any questions regarding the application, please do not hesitate to call me at [COLLECTOR PHONE].

Sincerely,

Billing Representative

Attachment
PLEASE COMPLETE AND RETURN BY: ________________________

*** FINANCIAL ASSISTANCE APPLICATION ***

NOYES MEMORIAL HOSPITAL
111 CLARA BARTON STREET
DANSVILLE, NY 14437
585-335-6038

GUAR: [GUARANTOR SS #]
[GUARANTOR NAME]
[GUARANTOR ADDRESS LINE]
[GUARANTOR CITY, STATE ZIP]

PATIENT ACCOUNT #   NAME    BALANCE
#   NAME    BALANCE
#   NAME    BALANCE
#   NAME    BALANCE
#   NAME    BALANCE
#   NAME    BALANCE

GROSS MONTHLY HOUSEHOLD INCOME: $ ________________________

PLEASE INDICATE THE MONTHLY AMOUNT YOU CAN AFFORD TOWARD YOUR HOSPITAL BILL $ __________.

NUMBER OF PERSONS IN THE HOUSEHOLD: ________________________

PLEASE LIST ALL PERSONS IN HOUSEHOLD:
NAME       AGE* RELATIONSHIP GROSS MONTHLY INCOME* *EXPLANATIONS
__________________________________________
__________________________________________
__________________________________________
__________________________________________

*If anyone listed over 18 and still a student, please list school/college.
*If anyone listed over 18 yrs of age with no income, please explain.

PLEASE ATTACH MEDICAID DENIAL LETTER, IF APPLICABLE, AND PROOF OF INCOME**
**Acceptable proof of income is Medicaid denial documentation and/or the last 4 weeks of paystubs, if employed. Also copy of current bank statement, if receiving Social Security. The last tax return (include copies of W-2's and attach all schedules) is acceptable
proof of income for the self-employed.

Upon request from Noyes Memorial Hospital, I give my consent to verify income from my employer(s) listed above. Furthermore, I will apply for any assistance (Medicaid, Medicare, Commercial Ins., etc) which may be available for payment of my hospital charge and will take any action necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. I understand that this application is made so that the hospital can judge my eligibility for uncompensated services, based on the established criteria on file in the hospital. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate. I understand that if I receive any Noyes Hospital bills during the application process that I can disregard them until a determination is made. I also understand that I must report any changes in my family household income if financial assistance is granted.

I understand that I must return this application and supporting documentation by the above date or financial assistance may be denied. I also agree to authorize New York State Social Services to release any information to Nicholas H. Noyes Memorial Hospital to assure accurate and timely application processing.

If I do not agree with the determination or denial of financial assistance, I understand that I have 14 days to submit a request for appeal in writing with supporting documentation to the Noyes Business Office, Attn: Collections Team Leader. A review will be performed and a final determination will be made and communicated within 30 days of the appeal request.

Guarantor Signature ___________________________ Date ______________

For Office Use Only

Adjusted ___________________________ Approval ___________________________