St. John’s Riverside Hospital

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Policy and Procedure Manual

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<th>Financial and Charity Care Program</th>
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MISSION STATEMENT

St. John’s Riverside Hospital ("SJRH" or the "Hospital") is dedicated to providing comprehensive medical and nursing care in a compassionate, professional, respectful and ethical manner to every patient, regardless of ability to pay. To accomplish this mission, SJRH makes available to all of its patients a medical care financial assistance program entitled Health Solution (the "Charity Care Program").

The Charity Care Program is designed to provide financial assistance for patients who are unable to pay for all or a portion of their medical expenses incurred at the hospital and who meet the eligibility guidelines established under the program.

The Charity Care Program only applies to medically necessary services. Services such as cosmetic surgery are not covered. However, urgent or emergency services should be provided irrespective of a patient’s eligibility under the program.

The Charity Care Program is subject to the availability of designated funding from the allocation in the hospital’s operating budget.

PROCEDURE

A. Notification Requirements
   1. The hospital will post signage advising patients about the availability of the Health Solution programs in its Inpatient Admissions,
Outpatient and Emergency Room Registration areas, and at 
Cashiering locations.
2. Signage will be posted in both English and Spanish.
3. Information about the Health Solution program will also appear on 
patient bills and statements.
4. A Financial Assistance Summary letter will be made available at all 
registration and cashiering locations. It will also be printed in 
English and Spanish (See Appendices A1 and A2)
5. Admissions, Registration, Billing and Collection staff will also advise 
and explain to patients about the availability of the Health Solution 
program to Self-Pay patients, and those patients who may inquire 
about the program, or who express difficulty with paying a bill.
6. Translation services will be available to assist patients requiring 
communication in another language.

B. Covered Services and Exclusions
1. The following services are covered under the Health Solution 
program, and will be provided regardless of a patient’s eligibility 
under this program:
   i. Emergency care services.
   ii. Medically necessary non-emergent inpatient, ambulatory 
surgery and outpatient services (including clinics).
2. The following services are excluded from the Health Solution 
program:
   i. Cosmetic procedures.
   ii. Physician services.

C. Geographic Areas Served under the Health Solution Program
1. For Emergency care services: All New York State residents.
2. For Medically necessary non-emergent inpatient, ambulatory 
surgery, and outpatient services (including clinics), the hospital’s 
Primary Service Area (PSA) includes all patients residing in the 
following counties: Westchester, Orange, Putnam, Rockland, Bronx,
Manhattan (New York), Brooklyn (Kings) and Queens.
3. The hospital may at its discretion and in consideration of exceptional 
circumstances extend financial assistance for medically necessary 
non-emergent services to patients outside of its primary service 
area.

D. Eligibility Requirements
The hospital’s Charity Care Program uses income and family size as the 
primary factors to determine eligibility for reduced rates. The income, family 
size, Federal Poverty Levels (FPL) levels and discounted sliding scale 
amounts referred to in this section are shown in Appendix B. The hospital 
applies the sliding scale percentage discounts using the rate of its highest 
payor, Blue Cross.

1. Uninsured individuals with documented income and family size 
levels that fall at or below 100% FPL will be entitled to pay the
amounts specified under the State's Nominal Payment Guidelines (as shown below):
   i. Inpatient Services - $150/Discharge
   ii. Ambulatory Surgery - $150/Procedure
   iii. All Ancillary Services - $150/Procedure
   iv. Adult ER/Clinic Services - $15/Visit
   v. Prenatal and Pediatric ER/Clinic Services – No Charge
2. In the event the total charges for the services rendered were less than either the Nominal Payment Guidelines amount, or the percentage discount of the Blue Cross rate, then the patient will only be liable for the lower amount. When applying a percentage of the Blue Cross rate to establish the discount, it will be for the specific service(s) rendered.
3. Uninsured individuals whose documented income and family size fall between 101%-150% of the FPL guidelines will be entitled to discounted fees based on a sliding scale for covered services based with the lowest incomes paying the lowest amount, and then increasing in equal increments up to a maximum of 20% of the rate for the service rendered.
4. Uninsured individuals whose documented income and family size fall between 151%-250% of the Federal Poverty Level (FPL) guidelines will be entitled to discounted fees based on a sliding scale for covered services from 20% of the rate for the service rendered capped at the higher rate.
5. Uninsured individuals whose documented income and family size fall between 251%-300% of the Federal Poverty Level (FPL) guidelines will be charged no more than the rates for the services rendered.
6. Individuals who qualify for financial assistance under the Health Solution program may receive additional fee discounts due to extraordinary circumstances, which will be reviewed and approved by the Director of Patient Accounts.
7. Individuals whose income and family size levels exceed 300% FPL and those with insurance may apply and qualify for financial assistance under certain circumstances which will be reviewed on a case-by-case basis, and approved by the Director of Patient Accounts. Some of these circumstances may include (but are not necessarily limited to):
   i. Insured individuals who are unable to meet the financial obligations under their policies (i.e., deductibles, copayments, co-insurance, etc.).
   ii. Individuals unable to meet their financial obligations due the extraordinarily high costs of service.
   iii. Conditions that are documented by the hospital’s medical staff that warrant special consideration.
8. Any deposits that may be required prior to non-emergent medically necessary care must be included as part of any financial aid consideration.
9. Recurring patients (i.e., those receiving service on three or more consecutive days) may have their sliding fee reduced when medical necessity documentation is received and reviewed.

10. All Self-Pay patient balances are subject to an additional 9.63% New York State Surcharge being added to the amount due.

E. Application Screening Process and Documentation Requirements

1. All interested individuals may apply for financial assistance under the Health Solution program by completing the application (see Appendices C1 and C2, for the English and Spanish versions, respectively). Applications are available at all Registration and Admitting areas, and from the Patient Accounts department’s Financial Assistance Unit.

2. Applications must be submitted within 120 days from the date of discharge (for inpatients) and the date of service (for outpatients). Patients will be allowed an additional 20 days to submit a completed application and documentation.

3. All patients will be screened for third party insurance. If there is no insurance coverage, the Financial Counselor will determine if the patient is potentially eligible for Medicaid or Family Health Plus.

4. Applicants may be requested to apply for coverage under Medicaid, or other applicable governmental or grant program. The Financial Assistance Unit will assist inpatients with the Medicaid application process, and will refer outpatients to the local Department of Social Services where they can apply.

5. Patients are required to document their income by presenting supporting documentation, such as:
   i. Prior year's tax return (from a responsible individual, if applicable)
   ii. Two current pay subs or letter from employer on company letterhead
   iii. Letter from the Department of Labor regarding unemployment
   iv. Social Security award letter or statement
   v. Other documentation as may be required to verify income: self-employment, annuities, unemployment income Worker's Compensation, Veteran's Benefits, military pay, interest, dividends, royalties, other income (e.g., from rents, other family member contributions, etc.)
   vi. Income from savings accounts, stocks and bonds may also be considered as income; supporting documentation for these assets may be required if the hospital elects to consider these assets for eligibility under the Health Solution program.
   vii. The following assets are excluded from consideration in determining income or available assets for eligibility under the Health Solution program: patient’s primary residence, assets held in a tax-deferred or comparable retirement savings accounts, college savings accounts, or cars used regularly by a patient or immediate family members.
6. Patients are required to document their identity and family size by presenting supporting documentation, such as:
   i. Birth certificates
   ii. Baptismal (or other religious) certificates
   iii. Marriage Certificates
   iv. Official school records
   v. Naturalization certificate
   vi. Passport
   vii. Death Certificates (where a change in family size status may be indicated, or to document certain funeral expenses)

7. Patients are required to document their residency (home address) by presenting supporting documentation such as:
   i. ID card with address
   ii. Postmarked envelop, postcard, or magazine label with name and date
   iii. Driver's license issued within the last six months
   iv. Utility bill or correspondence from a government agency which contains the name and street address
   v. Letter, lease, rent receipt with home address from landlord
   vi. Property tax records or mortgage statement

F. Determinations and Appeals Processes
   1. Patient applications for financial assistance will be denied if:
      i. False information was provided by the patient or his/her representative.
      ii. Patient or responsible party refuses to cooperate with the terms of the Health Solution program.
      iii. Patient or responsible party refuses to apply or cooperate with processing a government insurance program application.

2. Financial Counselors will review all applications and supporting documentation for completeness, and will contact patients about missing or incomplete applications. Completed applications meeting the required guidelines will be approved.

3. All determinations must be made within 30 days from the receipt of a completed application.

4. Approval letters will be sent to patients along with a Health Solution Identification card. Approvals will be valid for one year, and recertification under the program must be completed annually.

5. For all approvals, unique identifiers will be entered into the Meditech Patient Accounts system that will automatically apply the appropriate discount to the patient's account.

6. For all denials, letters will be sent to the patient advising them of the decision and reason for denial.

7. Patients will be advised that they may appeal a denial decision by sending a letter to the Supervisor of the Financial Assistance Unit requesting reconsideration.

8. The Manager of the Financial Assistance Unit will resolve appeals for reconsideration of denials within 10 business days of receipt, and advise the patient in writing of the reconsideration determination.
9. Patients whose appeals are not overturned will be advised that an additional appeal letter may be sent to a committee comprised of the Directors of Patient Accounts and Revenue Cycle, and the Chief Financial Officer.

10. This committee will issue its final determination status to the patient regarding the application for financial assistance.

G. Collection Practices

1. Patients eligible for financial assistance under the Health Solution program will have their open accounts adjusted to the amount due based on the level of assistance they receive, so that bills and statements will reflect the discounted amount due. Patients will then be expected to pay the adjusted amount due.

2. Patients who are unable to pay the adjusted amount due will be offered payment plans.

3. Payment plans will not require a patient to pay more than 10% of their monthly gross income towards monthly installment payments. If the hospital elects to consider other non-excluded assets in determining financial assistance eligibility, then monthly payments may exceed 10%.

4. The hospital will not collect from a patient who is determined to be eligible for Medicaid, or who is eligible for Medicaid at the time services were rendered.

5. If a patient or responsible party defaults on its payment obligations, or fails to meet the terms of any financial agreement, the account in question will be considered delinquent, and may be referred to a collection agency based on the hospital’s collection policy.

6. The hospital will not send an account to collection if the patient has submitted a completed application for financial aid, including required supporting documentation, while the hospital determines the patient’s eligibility for such aid, or during the process where the patient has appealed an eligibility determination.

7. The hospital will review all accounts determined to be referred to outside collection to ensure that its financial assistance policy and procedures were followed.

8. The hospital will provide written notification and a notice on the patient’s bill not less than 30 days prior to referring the account to outside collection.

9. The hospital will send each of its collection agencies a copy of its financial assistance policy and procedures, and will instruct the agency to follow these procedures when instructing the patient how to apply for such aid.

10. Collection agencies must obtain the hospital’s written consent prior to commencing a legal action on a patient’s account.

11. Legal action may include garnishment of wages where there is evidence that the patient or responsible party has income and/or assets to meet his/her financial obligations under this policy.
12. The hospital will not permit the forced sale or foreclosure of a patient’s primary residence in order to collect an outstanding medical bill.

H. Administrative and Reporting Requirements
1. The hospital will review this policy and procedures on a regular basis to ensure its consistency with the current regulations.
2. Statistics regarding patient applications, approvals and extent of financial assistance provided under this program will be maintained and reported to Administration.
3. Data will be provided to complete Exhibit 50 of the New York State Cost Report regarding Hospital Charity Care Reporting.
4. The hospital will provide training to Billing and Collection, and Admitting and Registration staff that will need to be most familiar with the financial assistance and charity care program.
5. The hospital will also provide system-wide general awareness information about the Health Solution program.

Approval:

__________________________  _______________________
Name/Title                                      Date