ELLENVILLE REGIONAL HOSPITAL

TITLE: FINANCIAL ASSISTANCE FROM HOSPITAL	**Page 1 of 6**
DEPARTMENT: PATIENT FINANCIAL SERVICES	
OTHER AFFECTED DEPTS: REGISTRATION	
APPROVED BY: BOB RUE, CFO	**EFFECTIVE: 6/04**
REVIEWED: 9/12, 7/14, 9/15, 7/17	**REVISED:1/07, 7/11, 06/13, 1/14, 9/16, 2/17, 7/18, 5/19, 6/19**

STATEMENT & PURPOSE:
To establish guidelines for processing and approving Financial Assistance.

POLICY:
Ellenville Regional Hospital (ERH) recognizes the responsibility to provide access to quality health care services that reflects the community's needs. Patients who present themselves for emergency or urgent care will not be turned away because of their inability to pay. Financial Assistance will be made available for medically necessary services, which are defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Non-medically necessary services such as cosmetic surgery, patient convenience items or elective procedures are not covered under the policy.

Financial assistance is offered to all patients who reside in New York State for emergency services. For all other necessary medical services, assistance is offered only for patients whose primary residence is within our primary service area (PSA). Our PSA is comprised of the following counties: Ulster, Dutchess, Orange, Sullivan, Delaware, Greene and Columbia.

Financial Assistance is defined as health care services provided at no charge or at a reduced charge to patients who do not have or cannot obtain adequate financial resources or other means to pay for their care. Partial or full Financial Assistance will be based solely on eligibility and will not be abridged on the basis of age, sex, race, creed, disability, national origin, or immigration status. ERH will provide care for emergency conditions regardless of financial status, without discrimination, in accordance with EMTALA regulations.

The patient responsibility of an uninsured patient who qualifies for financial assistance will be based on the reimbursement rate that ERH receives from Medicare. Discounts will be calculated using the Federal Poverty Line (FPL) from the Department of Health and Human Services and our sliding scale.

For insured patients, financial assistance will not be provided for copayments, nor will it be if the patient does not get required approval/referrals from their insurance. Financial assistance for insured patients will be allowed only if the ERH contract with the patient's insurance plan allows it. If the patient has a Health Reimbursement (HRA) or a Flexible Spending Account (FSA), the patient will be expected to use funds from this account before financial assistance can be granted.

TITLE: FINANCIAL ASSISTANCE FROM HOSPITAL	Page 2 of 6
DEPARTMENT: PATIENT FINANCIAL SERVICES	
OTHER AFFECTED DEPTS: REGISTRATION	
APPROVED BY: BOB RUE, CFO	EFFECTIVE: 6/04
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PROCEDURE:

1. After obtaining a request for financial assistance from the patient/guarantor, Patient Accounting will either give or mail the application to the requesting party. All private pay/uninsured patients are given a financial assistance packet at the time of registration; this is noted on the patient's account. Financial Assistance application can be requested while at this hospital or by phone, and also downloaded from the hospital's website.

2. Patient Accounting will review the patient's information for possible insurance coverage and other self-pay options, such as credit cards and payment plans. After all third party and personal resources have been exhausted, the patient will be evaluated for Medicaid. If Financial Counselor has a reasonable basis for believing an applicant is eligible for Medicaid, patient must cooperate in applying for coverage as a condition for applying for assistance.

    a. If Medicaid denies the application due to not qualifying, the patient/guarantor is responsible for supplying the Financial Counselor with a copy of the Medicaid denial letter.

    b. Upon receipt of the Medicaid denial letter, a hospital Financial Assistance application must be completed in a timely manner by the patient/guarantor. The time period to request financial assistance is 240 days from the date services were rendered.

    c. The patient/guarantor must provide proof of identification, address and income with their application.

        - Acceptable proof of identification includes: Driver license, passport, permanent resident alien card (Green Card), birth certificate, photo ID. At least ONE from this list must be supplied.
        - Acceptable proof of address/residency includes: Utility bills, cell phone bills, cable television bill, rent receipt, copy of lease or mortgage papers, notarized letter from person patient resides with or from landlord. At least ONE item from this list must be supplied.
        - Acceptable proof of income includes, but is not limited to: Recent pay stubs (4 if paid weekly, 2 if paid bi-weekly), unemployment benefits, award letter from Social Security Administration / Pension / Annuities.

3. The Financial Counselor will receive the required information along with the Financial Assistance application. If the information is found to be untrue, the application will be immediately denied.

TITLE: FINANCIAL ASSISTANCE FROM HOSPITAL	Page 3 of 6
DEPARTMENT: PATIENT FINANCIAL SERVICES	
OTHER AFFECTED DEPTS: REGISTRATION	
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4. The Financial Counselor will evaluate the information provided in the application in conjunction with the Poverty Guidelines that are issued each year by the Department of Health and Human Services (HHS) to determine appropriate discount. The most current U.S. Federal Poverty Guidelines used to determine financial assistance eligibility can be found at: https://aspe.hhs.gov/poverty-guidelines. The guidelines will be used in the sliding scale for uninsured patients. If applicant:

    - Is at 100% or below the FPL, they are entitled to a 100% discount.
    - Is between 100-150% of the FPL, responsibility will be 20% of the Medicare rate.
    - Is between 150-200% of the FPL, responsibility will be 50% of the Medicare rate.
    - Is between 200-250% of the FPL, responsibility will be 75% of the Medicare rate.
    - Is between 250-300% of the FPL, responsibility will be 100% of the Medicare rate.
    - Exceeds 300% of the FPL, no discount will be applied.

5. For insured patients at or below 150% of the FPL, the above discounts will still apply. Patients above 150% may still qualify for discounts, but will be reviewed on a case to case basis. Financial hardship and extenuating circumstances will be factored into decision.

6. If the information supplied supports the fact that the patient qualifies, an "Adjustment Request" form is completed and sent to the appropriate authorization level for approval.

Authorization Level	Approval Range
Financial Counselor	$0.00 - $1000.00
Patient Financial Services Manager	$1000.00 and above

7. After review and determination, the original is returned to the Financial Counselor. The hospital must approve or deny within 30 days of the completed application:

    a. If patient/guarantor is approved for any level of assistance, they will be mailed an approval letter detailing the level of discount that they have received.

b. For any level under the 100% discount, the patient/guarantor will be notified of the remaining balance on the approval letter. If the patient cannot pay the amount up front, a payment plan will need be established between the financial counselor and the patient/guarantor. Our payment plan guidelines state:

- Not to exceed a monthly amount of 10% of their gross income.
- Financial Counselor can ask for a deposit up front on reduced rates, but it cannot be "an undue obstacle".
- That no acceleration clause will be enforced if the patient cannot fulfill their obligation.
- In the event that the patient does not fulfill their obligation without notice to the billing office, the account(s) may be referred to a collection agency. The hospital will give notice at least 30 days prior to the referral to the agency.

c. If denied, a denial letter will be mailed to the patient/guarantor. The denial letter will clearly outline the steps required to appeal. All applicants have the right to appeal. The patient/guarantor will have 30 days to file a written appeal disputing the decision. Appeals will then be reviewed by the Patient Finance Manager with the previous application and a written redetermination will be made within 30 days from receipt of the appeal.

8. Financial Counselors will notate all activity in the Electronic Medical Record system and will file the original documents in the current Charity file. The Financial Counselor will also adjust the affected account(s) based on the discount given upon approval.

9. Once an applicant has qualified for Financial Assistance, the approval is active for six months from the approval date. The patient/guarantor can then update their application once allotted time has passed.

10. Quarterly audits are performed on a sample of approved and/or denial applications to ensure accuracy and fairness.

COLLECTION POLICIES

1. If the financial assistance applicant has submitted an application, there is a chance that they will receive a statement in the mail. The applicant is not responsible to pay the bill, which should be disregarded while application is in process.

TITLE: FINANCIAL ASSISTANCE FROM HOSPITAL	Page 5 of 6
DEPARTMENT: PATIENT FINANCIAL SERVICES	
OTHER AFFECTED DEPTS: REGISTRATION	
APPROVED BY: BOB RUE, CFO	EFFECTIVE: 6/04
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2. Medicaid eligible patients at the time of service are not to be sent to collections for an outstanding balance.

3. The financial assistance policy dictates that the collection agency that we contract with complies with the hospital's financial assistance policy and also provides information to patients on how to apply.

4. We do not send accounts to collection if an application for financial assistance is in process. Once an account(s) have been designated as Financial Assistance, statements will stop being sent until a determination is made.

5. Patients will receive notification that an account will be referred to collections at least 30 days prior to referral. The patient will receive two pre-collection agency letters approximately 15 days apart before being referred.

6. The collection agency that we contract with must obtain the hospital's written consent before commencing a legal action.

7. The financial assistance policy does not permit the force of sale or foreclosure of a patient's primary residence to collect on an outstanding bill.

PARTICIPATING INSURANCES

The link provided in this section will show which insurance plans ERH participates with. You may call us at (845) 647-6400 with any specific questions you have. You can also contact your insurance plan to confirm participation with the hospital as well.

Link: http://www.ellenvilleregional.org/patients-guests/paying-for-your-care/erh-participating-health-plans/

STANDARD CHARGES

The link provided in this section will provide you with a full transparent list of the hospital charges we use. All of these charges are uniform for all patients regardless of insurance. Out of pocket responsibilities will vary based on your insurance coverage with your carrier. If you have questions regarding charges or patient responsibility, we encourage you to contact us at (845) 647-6400.

Link: http://www.ellenvilleregional.org/patients-guests/paying-for-your-care/erh-standard-charges/

TITLE: FINANCIAL ASSISTANCE FROM HOSPITAL	Page 6 of 6
DEPARTMENT: PATIENT FINANCIAL SERVICES	
OTHER AFFECTED DEPTS: REGISTRATION	
APPROVED BY: BOB RUE, CFO	EFFECTIVE: 6/04
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PHYSICIAN SERVICES

It is important to note that physician services are billed separately and are not included in the hospital's standard charges. Physicians may or may not participate in the same insurance plans as the hospital, so please check with the physician arranging your hospital services to ensure they participate with your insurance. The link provided in this section includes all of the physician groups that the hospital currently utilizes.

Link: http://www.ellenvilleregional.org/patients-guests/paying-for-your-care/contract-providers-contact-information/

ATTACHMENTS / ADDITIONAL DOCUMENTATION

ERH FA Application (Dual Language):
http://www.ellenvilleregional.org/wp-content/uploads/2019-Financial-Assistance-Application-English-and-Spanish.pdf

ERH FA Document List (English):
http://www.ellenvilleregional.org/wp-content/uploads/2019-Financial-Assistance-Document-List-English.pdf

ERH FA Plain Language Summary (English):
http://www.ellenvilleregional.org/wp-content/uploads/2019-Financial-Assistance-Plain-Summary-English.pdf