Oneida Health

Policy Number: **FIN 004**
Original Date: 01/01/07
Revised: 08/31/07, 06/30/09, 07/14/15, 12/21/15, 01/19/16, 01/22/19, 06/01/2, 02/21
Reviewed:

Subject/Title: **Financial Assistance Policy**

Policy: It is the policy of Oneida Health to be in compliance with the Hospital Financial Aid Law.

Purpose: OH offers Financial Assistance to uninsured and underinsured patients at a reduced rate or at no charge to the residents of New York State who have individual or family income, which does not exceed 300% of the HHS Poverty level.

Services covered under this policy:

1. Admitted acute care patients
2. Emergency services, including emergency transfers pursuant to the Emergency Medical Treatment and Labor Act (EMTALA)
3. Ambulatory surgery patients
4. Referred ambulatory patients
5. Observation patients

Please note: Cosmetic and/or elective surgery considered not medically necessary services are not eligible for financial assistance.

Scope: This policy applies to all Board members, officers, managers, and other workforce members including, employees, trainees, volunteers, providers, consultants, independent contractors, students and temporary workers ("Affected Persons") and throughout Oneida Health (OH), including the hospital and all of its departments and health centers, and OH's affiliated physician practices (Oneida Medical Services, PLLC, Oneida Medical Practice, PC and Genesee Physician Practice, PLLC), and any other department or entity which is part of OH.

Procedure:

All patients are notified of our Financial Assistance Policy (FAP) at the time of registration by posted signs throughout the registration area, with the policy, a summary and application available at time of registration, and with notification sent with all billing statements.

Upon request, the policy, a summary of our Financial Assistance Program and an application are furnished to the patient.

Upon receipt of a completed application the claim is placed on a statement hold; payment is not expected while the application is in review.

Documentation requested with the application, for each member of the household, including dependents, is:

- Last eight (8) consecutive weeks of paystubs (four (4) if paid bi-weekly)
- Confirmation of unemployment, social security, pension, worker's compensation, disability, etc.
- For self-employed persons, a (3) month business ledger or self-attestation for (a tax return is optional)
- Medicaid Eligibility Status (if available from having recently applied).
- Where no type of income documentation is available, the self-attestation form may be used.
- Alimony or child support income
- All other sources of income

1. Approval for financial assistance will be based on a case-by-case basis. Determination will be made relative to household size and income level.

2. Based on the information provided on the application, **OH** will review criteria to identify if the patient may be eligible for NYS Medicaid coverage. If the information provided appears to meet eligibility guidelines, the patient will be advised to apply for NYS Medicaid to obtain NYS Medicaid approval or denial.

3. If **OH** is unable to make a determination based on information provided, a letter will be sent to the patient advising the application is pending until complete information/documentation is received. This must be returned in a timely manner and as specified by **OH** in order that an expeditious determination be made.

4. In the event it is necessary for a patient to apply for Medicaid and Medicaid denies based on failure to complete an application or refusal to comply with any conditions of eligibility this will result in the application for Financial Assistance being denied. You may be required to apply for any other insurance or programs prior to receiving financial assistance.

5. Account balances as a result of out of pocket expenses, benefits exhausted and denied insurance payment are eligible for financial assistance for hospital services. (This does not apply to the physician outpatient clinics).

6. Application for financial assistance must be made within 120 days (notification period) from the first post discharge patient billing statement. Thereafter, all supporting and any additionally requested documentation upon timely notification, must be received by the facility within the timeframes requested by the facility not to exceed an additional 120 days (application period).

7. The financial assistance approval will be valid for those accounts listed on the application only. Approval of financial assistance will be honored for a 6 month period; therefore, reducing the necessity for "re-application". However, if the financial status of a patient/guarantor has changed; **Oneida Health** will ask the patient/guarantor to re-apply.

8. Determination of the financial assistance award will be made by business office personnel. The application will then be given to the Director of Patient Accounts, Business Office Supervisor (Hospital) or the Central Billing Office Manager (Clinic side) for final approval. In cases where the account balances total greater than $15,000.00, approval of the Chief Financial Officer will be required.

9. Patients who have made application for financial assistance will receive a written determination from the Business Office within 30 working days of determination.

10. Patients who do not agree with the determination of eligibility for financial assistance may call the New York State Department of Health complaint hotline at 1 800 804 5447.

11. Financial assistance requests will not be honored until the final patient responsibility is determined after all insurances have paid their contracted portion. Any insurance disputes must be settled before the account balance will be considered.

12. Once a favorable determination has been made, the patient/guarantor will be provided notification along with an explanation of the expected time frames to remit balances due. The patient/guarantor will be requested to sign an agreement and return it to **OH** within 14 days.

13. When a guarantor/family has been approved for financial assistance the guarantor may pay the adjusted account balance(s) in full or if necessary can set up payment arrangements. Payment plan parameters are listed below.

    Account balance under $100.00 6 months – 9 months maximum

$100.00 - $ 500.00	9 months – 12 months maximum
$ 501.00 - $ 1000.00	12 months maximum
$ 1001.00 - $ 3000.00	18 months maximum
$ 3001.00 - $ 5000.00	24 months maximum
Over $5000.00	

Contact the Business Office for payment arrangements
Monthly payments will not exceed 10% of the guarantor/family gross income.

14. The New York State surcharge amount, if applicable, will be an additional charge to the final discounted account balance.

15. A financial assistance monthly accounting will be maintained indicating the patient name, account number, date of service, type of service, date of application, date of approval/denial, total charges, total balance due from patient, adjustment amount, zip code, and adjusted patient balance.

16. Copies of the application, approval/denial, summary bill and any correspondence relative to the financial assistance application will be maintained on file for a period of 10 years.

17. We maintain separate billing and collection policies. Copies are available upon request.

18. The list of providers not covered by our Financial Assistance Policy (FAP) can be found at the following link : https://www.oneidahealth.org

Oneida Health
2021 Federal Poverty Levels

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$ 12,880	$ 17,130	$ 19,320	$ 25,760	$ 32,200	$ 38,640	$ 51,520
2	$ 17,420	$ 23,169	$ 26,130	$ 34,840	$ 43,550	$ 52,260	$ 69,680
3	$ 21,960	$ 29,207	$ 32,940	$ 43,920	$ 54,900	$ 65,880	$ 87,840
4	$ 26,500	$ 35,245	$ 39,750	$ 53,000	$ 66,250	$ 79,500	$ 106,000
5	$ 31,040	$ 41,283	$ 46,560	$ 62,080	$ 77,600	$ 93,120	$ 124,160
6	$ 35,580	$ 47,321	$ 53,370	$ 71,160	$ 88,950	$106,740	$ 142,320
7	$ 40,120	$ 53,360	$ 60,180	$ 80,240	$100,300	$120,360	$ 160,480
8	$ 44,660	$ 59,398	$ 66,990	$ 89,320	$111,650	$133,980	$ 178,640
Sliding Scale	100%	89%	79%	69%	59%	49%	0%

Other related Policies/Procedures:
Previous Policy #:
References: Section 501(r) of the IRS code, effective 2016
Standards:

Forms: **Financial Assist Plain Language Summary (01242)**
Financial Assistance Application (01913)
Paying for Care – Contracted Services (01519)

Approved By: V. Cole, J. Sweet 06/2020