EASTERN NIAGARA HOSPITAL PATIENT ACCOUNTING POLICY AND PROCEDURE		PAGE 1 of 6	EFFECTIVE DATE: January 2004		
POLICY TITLE: **Financial Aid / Charity Care and Debt Collection Standards**			REVIEW & REVISION HISTORY		
			REVIEWED	REVISED	INITIALS
			6/06		CMH
				1/07	CMH
PREPARED BY:	REVIEWED BY: *(If applicable)*	APPROVED BY:	4/08		CMH
			1/10		CMH
			12/12		CMH
CFO		Board of Directors	3/13		CMH
			3/14		CMH
			4/15		CMH
			3/16		CMH

A. POLICY STATEMENT

The Board of Directors has established that the Hospital is committed to serving patients whether or not they can pay for part or all of the essential medical care they receive. Further, in no circumstance, shall the Hospital ever divert a patient seeking emergency health care based upon ability to pay or source of insurance.

B. PURPOSE

The Hospital is a not-for-profit organization, focused on its mission of caring for patients' 24 hours a day, seven days a week, 365 days a year, regardless of ability to pay.

C. PROVISIONS

1. The Hospital does not wish to have fear of a bill precluding a resident of its community from seeking or obtaining essential health care services. The Board of Directors has authorized the Administration to proactively convey this message to prospective patients, the public in general and local community service agencies as applicable.

2. The Hospital's financial aid policies shall be consistent with the mission and values of the Hospital. That shall not preclude Hospital efforts to take into account each individual's ability to contribute to his or her care.

3. The Hospital is committed to providing such financial aid as is consistent with its mission and the Hospital's resources to provide uncompensated care.

4. Financial aid policies shall be clear, understandable and communicated in a manner that is dignified. As applicable, policies will be communicated in multiple languages appropriate to the patients served.

5. Debt collection policies – internal and by external collection agencies – shall be consistent with the mission of the Hospital.

6. Financial aid policies do not eliminate personal responsibility. Eligible patients are encouraged to access public or private insurance options. All patients are expected to contribute to their care based on their individual ability to pay.

III. ELIGIBILITY FOR FINANCIAL AID

A. Premises

1. Financial aid is intended to assist low-income or uninsured individuals who cannot afford to pay in full for their care. It should take into account an individual's ability to contribute to the cost of his or her care.

2. Patients who have exhausted their insurance benefits and / or who exceed financial eligibility criteria but face extraordinary medical costs should be dealt with on a case by-case basis.

3. Hospital financial aid is not a substitute for employer-sponsored, public, or individually purchased insurance.

B. Policies

The Board of Directors authorizes the CEO to ensure the development of financial aid policies that shall:

1. Plainly state the eligibility criteria to receive financial aid. Such policy shall include the following:
   - Whether assets will be used in determining eligibility. If used, they should be adjusted to exclude a primary home, first car, and some savings.
   - Define the type and scope of any nonessential services not eligible for financial aid (e.g.: discretionary, nonreconstructive plastic surgery)
   - Financial aid to individuals is contingent on cooperation from the individual to establish to the Hospital's reasonable satisfaction that a need exists. Patients or their legally responsible parties should cooperate with the Hospital's need for accurate and detailed financial information. Therefore, any patient seeking financial aid shall provide the Hospital with

financial and other information needed to determine eligibility for financial aid, or to assist in enrolling in a publicly sponsored insurance program (e.g., Medicaid, Family Health Plus, Child Health Plus), if eligible. Documentation requirements should be easy to follow (e.g., require easily obtainable documents such as pay stubs, tax returns, mortgage papers, rent receipts, etc.).

2. Provide appropriate financial assistance to those in need as evidenced by the following:
   - Significant financial assistance will be provided to the lowest income individuals – those below 200% of the Federal Poverty Level (FPL) – with collection practices that recognize the limited financial capacity of those individuals.
   - Some financial assistance will be provided to those who earn 200% of the FPL but who for various reasons still face challenges in making full payment.
   - Collection policies and practices that are adjusted based on patients' ability to pay.

3. Should Hospital resources, from time to time, require prioritization of financial aid needs, then priority shall be given to patients in the communities of Eastern Niagara County.

4. Discount Policies

   (a) The Hospital shall determine sliding scale discounts in a reasonable manner based on what low-income patients can afford to pay.

   (i) For low-income uninsured (i.e., below 200% FPL), the Hospital will
   - apply discounts to fixed payment standards (e.g., Medicaid or third-party payer rates, etc., federal rules and regulations permitting) as opposed to charges or
   - ensure that the resulting payment does not exceed prices charged to an insured patient.

   (ii) The Hospital's approach shall:
   - Incorporate flexible payment plans (e.g., extended payment terms).
   - Clearly state if a minimum / nominal payment is required.

(iii) Amounts of discounts provided will be based on the following schedule

% Of Federal Property Guidelines	**Charity Care Discount**
<101%	100% Charity Care
101% - 150%	75% Discount From Fee Cap Rate
151% - 200%	50% Discount From Fee Cap Rate
201% - 250%	25% Discount From Fee Cap Rate
251% - 300%	Fee Cap Rate

The Cap Rate is calculated as follows:
Inpatient – Community Blue Rate
Outpatient – Medicare % of reimbursement to charges

(iv) In order to qualify for charity care discounts individuals must complete an application and provide the following documentation:

- ***3 recent payroll check stubs***
- ***Most recent tax return***
- ***Unemployment records***
- ***Documentation of government benefits***

(v) Patients must sign that all information provided under the charity care application. Any approval for charity care can be revoked if the application is found to be fraudulent.

(b) Policies will be evaluated on a regular basis.

(c) Different discount scales may apply to different categories of services (e.g., ambulatory or clinic care).

IV. COLLECTION POLICIES

A. The Hospital's collection policies shall be consistent with the mission of the Hospital.

B. The Hospital will work with its patients to establish a reasonable payment plans that take into account available income and assets, the amount of the bill and any prior payments.

C. Legal action, including the garnishment of wages, may be taken by the Hospital when there is evidence that the patient or responsible party has sufficient income and/or assets to meet his or her obligation.

D. The Hospital will not execute a lien by forcing the sale or foreclosure of a patient's primary residence to pay for an outstanding medical bill.

E. For inpatient and high-cost care, the Hospital will review the patient's record to determine (as feasible) whether financial assistance is appropriate before any collection agency assignment.

F. The Hospital will direct its external collection agencies to follow these guidelines.

V. PROGRAMMATIC FACTORS

A. Communication

1. Policies should be written in easily understandable language.

2. The Hospital will take affirmative efforts to assist patients who have language barriers.

3. The availability of financial aid will be communicated as follows:
   - ***Posting in admissions***
   - ***Information sheet available in admissions for patients with no insurance coverage***
4. Patients will, as appropriate, be educated about their responsibilities, the potential financial obligation they may incur, their obligations for completing eligibility documentation and the Hospital's bill collection policies.
5. Information about the availability of Hospital financial aid/charity care shall be conveyed to appropriate community health and human service agencies and other organizations that assist people in need.

B. Hospital Assistance to Identify Sources of Payment

Financial assistance provided by this Hospital is neither infinite or a substitute for the responsibility of government, employers and individuals. Financial aid policies do not eliminate personal responsibility. Eligible patients are encouraged to access public or private insurance options. All patients are expected to contribute to their care based on their individual ability to pay.

The Hospital will refer patients to a facilitated enroller and / or provide assistance regarding applying for Medicaid, Family Health Plus, and/or Child Health Plus for future health care needs. In addition, Hospital may educate patients about their responsibility to obtain available insurance.

C. Staff Education and Training

1. The Hospital shall provide periodic information / training to staff about financial aid availability, as follows:
   - General staff – including caregivers, switchboard operators and receptionists – should be aware that there is a financial aid policy and how to direct a patient to the appropriate staff, who can provide the patient with detailed information.
   - Key public access staff – such as admitting staff, billing staff and cashiers – should have more detailed knowledge of eligibility requirements and the application process.
   - Staff who directly assists individuals in applying for financial aid, often with the authority to make eligibility determinations, shall be fully trained on the policies and how to communicate with patients.

2. Translation services will be available as needed and appropriate.

D. Program Implementation and Monitoring

1. The Hospital Administration shall periodically review and audit the patient notification and eligibility process and other implementation related issues.

2. The Hospital will monitor the effectiveness of the staff training program.

3. Policies should be reasonable, simple, respectful and promote appropriate access to care and responsible utilization of services.

VI. BOARD OVERSIGHT

A. The Hospital Board shall be provided with information on the extent of the charity care and financial aid provided, as well as the administration of the financial aid policy at least once annually. This shall occur simultaneously with the presentation of the Community Service plan submitted to the NYSDOH each year.

B. The Hospital will include information about its aid and charity care as an additional means of publicly communicating the community and patient benefits and services it provides.

C. The Hospital is committed to working with government, payers, business, consumer groups, and others to address the underlying problem that too many New Yorkers lack health insurance.

D. This policy on Financial Aid / Charity Care Standards may only be revised by action of the Board of Directors.

D. DISTRIBUTION

Hospital Manual
Patient Accounting Manual
Patient Registration Manual

EXHIBITS

I Charity Care Income Guidelines
II Charity Care Application
III Charity Care Adjustment Reqeust

EASTERN NIAGARA HOSPITAL
2017 CHARITY CARE INCOME GUIDELINES

Size of Family	Family Income Less Than				
1	12,060	18,090	24,120	30,150	36,180
2	16,240	24,360	32,480	40,600	48,720
3	20,420	30,630	40,840	51,050	61,260
4	24,600	36,900	49,200	61,500	73,800
5	28,780	43,170	57,560	71,950	86,340
6	32,960	49,440	65,920	82,400	98,880
7	37,140	55,710	74,280	92,850	111,420
8	41,320	61,980	82,640	103,300	123,960
HOSPITAL DISCOUNT	**100%**	**75%**	**50%**	**25%**	**CAP RATE**
PATIENT SHARE	**0%**	**25%**	**50%**	**75%**	**100%**

FOR FAMILIES LARGER THAN EIGHT, ADD $4,160 FOR EACH ADDITIONAL PERSON.

ENH
Committed to Caring

EASTERN NIAGARA HOSPITAL
521 East Avenue
Lockport, New York 14094
(716) 514-5700

Outpatient Sites:
5875 Transit Road
Lockport, NY 14094
2600 William Street
Newfane, NY 14108

CHARITY CARE APPLICATION

PATIENTS NAME:_____

ADDRESS:_____

GUARANTOR'S NAME:_____

TOTAL HOUSEHOLD
INCOME:_____ $_____ $_____ $_____
WEEKLY MONTHLY YEARLY

**ATTACH PROOF OF INCOME

HOUSEHOLD MEMBERS

NAME	BIRTHDATE	S.S#	RELATIONSHIP

Do you or any family members listed above have any other open accounts with Eastern Niagara Hospital? Yes____ No____
If Yes, please provide us with the account numbers and/or dates of service:

Patient's Name	Account #	Date of Service	Amount

Please return or mail this completed application along with proof of income to:

Eastern Niagara Hospital
Attn: Patient Accounting
521 East Avenue
Lockport NY 14094

If you have any questions or concerns, please call us at (716) 514-5898.

APPLICANTS SIGNATURE:_____ **DATE:**_____
CERTIFICATION: In signing this application, I swear and affirm that the information I have given or will give to Eastern Niagara Hospital as a basis for Charity Care is correct.

ENH
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CHARITY CARE
ADJUSTMENT REQUEST

Patient Name:_____ **Total adjustment requested:$**_____

Account #_____ **DOS**_____ **Account Balance $**_____

Account #_____ **DOS**_____ **Account Balance $**_____

Account # _____ **DOS**_____ **Account Balance $**_____

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EXPLANATION OF REQUEST FOR ADJUSTMENT:_____

Requested by:_____ Date_____
Name and Title of employee requesting adjustment

Approved by:_____ Date_____
Director of Patient Accounting

_____ Date_____
Chief Financial Officer