ADMINISTRATIVE DIRECTIVE

DIRECTIVE NUMBER: MV-04-005 **REVISION:** 1

DIRECTIVE TITLE: FINANCIAL ASSISTANCE PROGRAM **DATE:** 1/1/16

CONCURRENCE:

Dr. Albert D'Accurzio
Senior Vice President/Chief Medical Officer

Patricia Roach
Senior Vice President/Chief Nursing Officer

OWNER: Linda L. Burt
Director of Patient Accounting FSLH

APPROVAL: Louis Aiello
Senior Vice President/Chief Financial Officer

1.0 PURPOSE

To provide financial assistance to our patients for medically essential services who are uninsured or underinsured or have accumulated patient responsible balances after insurance payments, with an inability to commit to a financial agreement.

2.0 SCOPE

Mohawk Valley Health System (MVHS) including Faxton St. Luke's Healthcare (FSLH) and St. Elizabeth's Medical Center (SEMC).

3.0 REFERENCES

New York State Public Health Law 9-a Section 2807-k
Federal Tax Code Section 501 (r)
MV-04-005 Form 1 Financial Assistance Application/Determination

4.0 DEFINITIONS / ABBREVIATIONS

MVHS	Mohawk Valley Health System
FSLH	Faxton St. Luke's Healthcare
SEMC	St. Elizabeth Medical Center
FA	Financial Assistance
FAP	Financial Assistance Program
FC	Financial Counselor

5.0 PROCEDURE / DIRECTIVE

5.1 Eligibility: Mohawk Valley Health System is willing to extend financial assistance to all eligible individuals who reside in Oneida, Madison or Herkimer Counties. Patients residing in other areas will be reviewed on a case-by-case basis. We do not limit availability of financial assistance based on residency. Financial Assistance (FA) is offered to patients who have urgent, emergent, and medically necessary procedures consistent with Subdivision 9-a to Section 2807-k of the New York State Public Health Law.

The following criteria must be met in order to be eligible for financial assistance:

a. If there is no asset estate and there is no surviving spouse or when there are limited funds and the attorney has the capability of settling for a lesser amount of the bill. This does not include Medicare bad debt accounts.
b. Any patient who does not qualify for Medicaid and provides documentation of limited funds.
c. A minor when parental responsibility cannot be established.
d. Patients who are indigent, transient, and no medical coverage available.

e. Any patient not qualified for Medicaid, with limited funds, minimal or no insurance coverage, and is incapable of payment.
f. Patients who have exhausted his/her insurance benefits and demonstrates no further ability to pay for services.
g. Accounts returned to MVHS by our collection agencies and are designated by the collection agency as eligible for financial assistance.
h. Any patient, who is left with a patient responsibility of coinsurance, copayment, or deductible by his/her insurance, is not eligible for Medicaid, has limited funds, but is capable and willing to settle the account for a lesser amount.
i. Eligibility on a one-time basis during the closed enrollment period of NYS Department of Health for current services through November of the same year when the open enrollment period begins again.

5.2 Application Process

a. Brochures and signage in multiple languages are available at registration sites to notify patients and family members of the existence and availability of the Financial Assistance Program (FAP). The hospital website and billing statements include the phone number of our Financial Counselor (FC) staff. Our Patient's Insurance Guide includes all of our payment options and contact information. MV-04-005 Form 1 Financial Assistance Application/Determination is available on the hospital website – www.mvhealthsystem.org/billing.

b. A patient or guarantor requesting financial assistance will have up to ninety (90) days from the date of service/discharge to apply for the program. The following information must be provided with the completed application to aid in the decision by the hospital to provide free care. The time limit may be waived in extenuating circumstances such as waiting for Medicaid Approval.

1) MV-04-005 Form 1 Financial Assistance Application/Determination provided by the Hospital must be completed and submitted in its entirety within (30) thirty days of receipt of the application.

2) Proof of income and resources is required of the patient and all family members, if applicable. The various types of proof of income are listed on MV-04-005 Form 1 Financial Assistance Application/Determination. The proof of income includes, but is not limited to: income from wages (last three months pay stubs), self-employment, unemployment, social security, pensions, compensation, public assistance, alimony, child support, interest earned, rental dividends, VA benefits and complete copy of tax forms for prior year, etc. The following assets are excluded: patients' primary residence (owned home), car used by the patient or patient's family, college savings accounts, and tax deferred or comparable retirement savings accounts.

3) The following are not eligible for financial assistance program:

a) Accounts with collection agencies where the patient has shown no effort to pay his/her bill.

b) Non-compliance by the applicant in providing all necessary information to determine eligibility.
c) Elective non-covered services such as bariatric surgery, cosmetic surgery, dental surgery, hearing aids, or therapies outside the scope of a physician's orders.

5.3 Review Process

a. Accounts from the date of the application will be placed on hold for any collection efforts until a determination has been made for financial assistance eligibility.

b. Applications will be reviewed by the hospital within thirty (30) days of receipt of the completed application and supporting documentation. Accounts will be adjusted per the sliding scale from the date of the application and all qualifying future bills until the end of the calendar year (December 31). A new financial assistance application must be completed each year thereafter as the need necessitates.

c. The patient will be notified of the decision in writing. If the application is denied, the reason for the denial will be provided to the applicant. If you wish to appeal the decision, please contact the applicable Business Office where services were rendered FSLH (315) 624-5170 or SEMC (315) 801-3108. You may also contact NYS DOH 1 (800) 804-5447 or 1 (518) 402-6993. Examples of reasons for denial of the application include:

1) The patient did not comply with the policy requirements within thirty (30) days of application.
2) The patient is over the income limits to qualify for financial assistance. At this time all payment options will be reviewed with the patient. MVHS offers a 5-month interest free hospital loan and an interest free bank loan.

d. A written appeal may be filed within thirty (30) days of the patient's receipt of the decision. The Hospital will review the appeal and notify the patient in writing of the determination within thirty (30) days of receipt of the appeal from the patient. The appeal process is noted on the decision letter sent to the patient. If the appeal is denied, the patient will be sent five statements throughout the 120 day billing cycle. The last statement will advise the patient the account will be sent to collections.

e. Appeal may be based on the following:

1) Change in the patient's financial status.
2) Incorrect information provided.
3) Extenuating circumstances.

5.4 Financial Guidelines

(See attached MV-04-005 Form 2 Schedule A)

5.5 Financial Assistance

(See attached MV-04-005 Form 2 Schedule A)

5.6 Payment Arrangements/Collection

a. Patients accepted into the Financial Assistance Program must make regular monthly payments on the balance due for a maximum of five (5) months, not to exceed 10% of their gross monthly income. If three consecutive payments are missed, accounts may be sent to an outside collection agency.

b. Any discount given will remain in the event that an account is sent to a collection agency.

c. MVHS will not force the sale or foreclosure of a patient's primary residence to collect an outstanding bill.

d. Collection agencies will obtain MVHS's written consent before commencing legal action.

e. A patient will be notified at least 30 days before an account is transferred to a collection agency.

f. Collection action will not be taken on any Medicaid-eligible services.

g. The Director of the Business Office, or designee, will monitor compliance with these policies and procedures.

5.7 Prompt Pay Discount: f you are over income and have been denied for the FAP, MVHS offers a self-pay discount for the uninsured patients. Contact the Business Office at FSLH (315)624-5170 or SEMC (315)734-3108 for assistance.

6.0 FLOWCHART / SIPOC *(If procedure)*

N/A.

7.0 REVISION / REVIEW HISTORY

REVISION	DESCRIPTION	DATE
1	New policy. Replaces FSLH Policy FN-14-OP, Uncompensated Care Program, and SEMC Policy BOP008.001, Mother Bernardina Charity Care Program	10/1/15