

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT: FINANCIAL AID POLICY

NUMBER: JF14.1

OWNER: Office of the President

**EFFECTIVE
DATE: 4/86**

**REVISED
DATE: 11/22/11**

SUPERSEDES:

REFERENCE:

PURPOSE:

Montefiore Medical Center is guided by a mission to provide high quality care for all of its patients. We are committed to serving all patients, including those in our service area who lack health insurance coverage and who cannot pay for all or part of the essential care they receive at Montefiore. We are committed to treating all patients with compassion, from the bedside to the billing office, including payment collection efforts. Furthermore, we are committed to advocating for expanding access to health care coverage for all New Yorkers.

The medical center is committed to maintaining financial aid policies that are consistent with its mission and values and that take into account an individual's ability to pay for medically necessary health care services.

POLICY GUIDELINES:

This policy is intended to cover the medical center's guidelines for administering financial aid services to patients requiring medically necessary treatment after exhausting all sources of insurance payment. Financial aid is provided to patients with a demonstrated inability to pay, as contrasted to an unwillingness to pay, which is considered bad debt.

1. Financial aid shall be available to: (See Attachment A for Financial Aid Chart and Levels)

- Uninsured patients residing in Montefiore’s service area receiving medically necessary services who do not have the ability to pay based on formal financial criteria (Attachment A).
 - Patients receiving services that have insurance coverage but have an out-of-pocket expense may be eligible for financial assistance, including extended payment arrangement upon request. Any financial aid allowance shall be made on a case-by-case basis.
2. Except for emergency services, patient must reside within the medical center’s service area for a particular service to be categorically eligible for financial aid. Eligibility for financial aid for out-of-area patients will be determined on a case-by-case basis. The primary service area includes the five boroughs and Westchester County.
 3. Determination of eligibility for financial aid will be made as early in the care planning and scheduling process as possible. Emergency services shall never be delayed pending any financial determinations. Patients can apply for financial aid prior to services or after receipt of a bill. A patient can also apply for financial aid if bill has been sent out to a collection agency. There is no set limit for when the patient can apply.
 4. Elective procedures and services that are not deemed medically necessary (e.g., cosmetic surgery) are not eligible for financial aid.
 5. The patient or financially responsible party is expected to cooperate with the medical center in applying for available public or private insurance coverage (e.g., Medicaid, Child Health Plus, Family Health Plus, No Fault, Worker’s Compensation) if deemed potentially eligible before final financial aid determinations will be made.
 6. Gross income tied to published federal poverty income guidelines adjusted for family size, shall be used to determine eligibility for financial aid. Primary residence, college savings accounts, cars used by a patient or immediate family member or assets held in a tax-deferred or comparable retirement savings account are not reviewed or utilized in determining eligibility for financial aid. Decisions are based on annual income and family size.
 7. Other financial factors, including patient/family liabilities and other financial obligations, may be considered on a case-by-case basis in determining eligibility for financial aid.
 8. The medical center shall verify income using the most recent federal income tax return as well as non-taxable interest, social security or pension income. The patient or financially responsible party shall cooperate with the medical center to obtain a copy of the tax return as permissible under state and federal law. Alternate acceptable proof of income when tax return is not available or income level has changed is as follows:
 - Unemployment statement
 - Social Security/Pension Award letter
 - Paystubs/Employment verification letter
 - Letter of support

According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered as a dependent for purposes

of the provision of financial assistance.

9. Finance staff will be available to assist with financial aid consultations. Applications for financial aid will be reviewed and decided upon promptly and within 30 business days for non-emergency services. Patients have 30 days to complete application and patients have 30 days to appeal initial financial aid decision. Patient will receive financial aid decisions via mail with notification on the bottom of approval/denial letter explaining how to appeal decision. Patients are advised to disregard any bill received while application is in process. Patients that have completed a financial aid application shall not be sent to collections.

10. Notice of the medical center's financial aid policies shall be communicated in writing to patients and local community service agencies. Written information describing the medical center's financial aid policies shall be available in both English and Spanish to any party seeking such information at the following locations:
 - Admitting Offices
 - Registration Offices
 - www.montefiore.org
 - By mail upon request
 - The Call Center at 718-944-3800
 - Financial Aid availability and office phone number are printed on the bottom of all hospital bills.
 - Signs are posted at the entranceways in English and Spanish advising patient of the room location for Financial Aid.

All intake, registration, and collection agency staff is trained on the medical center's financial aid policy. An in-service is provided to all areas with instructions on where to send patients that need assistance.

11. Any decision can be appealed. The patient must provide proof of current income and expenses and last 2 bank statements. Patient has 30 days to complete appeals application and will be notified of decision via mail within 30 days of completion of the appeals application. Based on information provided patient will be evaluated for further reduction or extended payment plan.

12. The clinic sliding fee scale program (Administrative Policy dated April 1986, revised October 1998). Uninsured patients may apply for the clinic program. Any patient enrolled in the clinic sliding fee scale program shall be eligible for financial allowances for other medically necessary services not covered in above.

13. Uninsured patients receiving ambulatory services who are not enrolled in the medical center's clinic sliding fee program may be eligible for other financial assistance including extended payment arrangements upon request. Any financial aid allowances will be based upon extenuating financial circumstances and shall be made on a case-by-case basis. Approval by the Director of Patient Support Services; Associate Vice President, Health Service Receivables; Vice President, Professional Services; Vice President, Finance; or Senior Vice President, Finance, shall be required to authorize charity allowances in these circumstances.

14. Patients receiving inpatient or high-cost ambulatory services who have insurance coverage but have a large out-of-pocket expense may be eligible for financial assistance including extended payment arrangements upon request.

Any financial aid allowances shall be made on a case-by-case basis and require the approval of the Associate Vice President, Health Service Receivables; Vice President, Professional Services; or Vice President, Finance.

15. The medical center does not place a limit on services based on a patient's medical condition.
16. Patients are offered payment plans if they are not able to make reduced payment in full. Monthly payments are not to exceed 10% of patient's monthly income. Extended payment plans are also offered through the appeals process. If the patient makes any deposit it is included as part of payment towards financial aid balance.
17. There is no interest charged to financial aid patients and the patient will receive a final notice 30 days prior to any account being forwarded to a collection agency.
18. All collection agencies affiliated with the medical center must obtain the hospital's written consent before commencing with legal action.
19. The medical center prohibits collections against any patient who is eligible for Medicaid at the time services were rendered.
20. All collection agencies affiliated with the medical center have a copy of the medical center's financial aid policy and will refer any patient needing assistance back to the medical center for evaluation and reduction of bill based on annual income and family size.
21. The Financial Aid office measures compliance with its policy by sending out its own silent shopper to the intake and registration areas to ensure signage and summaries are posted and available and that associates are aware that the medical center offers Financial Aid.
22. Full Financial aid shall be granted to patients with outstanding self-pay bills and current Medicaid coverage.
23. Immigration status is not a criterion used to determine eligibility.
24. The Medical Center's charity care policy allows reclassification of accounts from bad debt to charity care based on predictive analysis results.
25. The family income limit for eligibility for free care is 150% of the Federal Poverty guidelines.

Any exceptions to the limits above shall be made on a case-by-case basis and require the approval of the Associate Vice President, Health Service Receivables; Vice President, Professional Services; or Vice President, Finance.

In implementing this policy, Montefiore Hospital's management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

Attachment A: Financial Aid Chart and Levels

FINANCIAL AID ELIGIBILITY CHART												
		GROSS INCOME CATEGORIES (Upper Limits)										
		C1 - MCD	C2	C3	C4	C5	C6	9M	**10	**11	**12	
Family Size	<100%	100%	125%	150%	175%	185%	200%	300%	400%	500%	over 500%	
1		10,890.00	13,613.00	16,335.00	19,058.00	20,147.00	21,780.00	32,670.00	43,560.00	54,450.00		
2		14,710.00	18,388.00	22,065.00	25,743.00	27,214.00	29,420.00	44,130.00	58,840.00	73,550.00		
3		18,530.00	23,163.00	27,795.00	32,428.00	34,281.00	37,060.00	55,590.00	74,120.00	92,650.00		
4		22,350.00	27,938.00	33,525.00	39,113.00	41,348.00	44,700.00	67,050.00	89,400.00	111,750.00		
5		26,170.00	32,713.00	39,255.00	45,798.00	48,415.00	52,340.00	78,510.00	104,680.00	130,850.00		
6		29,990.00	37,488.00	44,985.00	52,483.00	55,482.00	59,980.00	89,970.00	119,960.00	149,950.00		
7		33,810.00	42,263.00	50,715.00	59,168.00	62,549.00	67,620.00	101,430.00	135,240.00	169,050.00		
8		37,630.00	47,038.00	56,445.00	65,853.00	69,616.00	75,260.00	112,890.00	150,520.00	188,150.00		

* Based on the 2011 Federal Poverty Guidelines

Emergency Room Visit: (sliding scale based on average Medicaid rate)

- up to 100% of Federal Poverty Level- \$15 for Adults and \$0 for Pediatrics
- up to 125% of Federal Poverty Level-- \$80.00
- up to 150% of Federal Poverty Level-- -\$100.00
- up to 175% of Federal Poverty Level-\$125.00
- up to 185% of Federal Poverty Level-\$160.00
- up to 200% of Federal Poverty Level- \$239.00
- up to 300% of the Federal Poverty Level -\$319.00
- up to 400% of Federal Poverty Level -\$479.00
- up to 500% of Federal Poverty Level-\$638.00
- Over 500% of Federal Poverty Level - highest contracted rate (\$1231).

Emergency Inpatient Admissions:

- up to 100% of Federal Poverty Level - \$150 per discharge
- 100% to 150% of the Federal Poverty Level- full aid with \$200 deductible
- 150% to 175% of the Federal Poverty Level- 25% of Medicaid Rate

- **175% to 185% of the Federal Poverty Level- 50% of Medicaid Rate**
- **185%-200% of the Federal Poverty Level – 75% of Medicaid Rate**
- **200% to 300% of the Federal Poverty Level- 100% of Medicaid Rate**
- **300% to 500% of the Federal Poverty Level- Blue cross Indemnity Rate**
- **Over 500% of Federal Poverty Level -Highest contracted rate.**

Clinic visits (for Montefiore Practice Locations)

- **up to 100% of Federal Poverty Level - \$15 for adults and \$0 for Prenatal and Pediatrics**
- **up to 125% of the Federal Poverty Level- \$49.00**
- **up to 150% of the Federal Poverty Level- \$60.00**
- **up to 175% of the Federal Poverty Level-\$71.00**
- **up to 185% of the Federal Poverty Level-\$82.00**
- **up to 200% of the Federal Poverty Level - \$104.00**
- **up to 300% of Federal Poverty Level -\$126.00**
- **up to 400% of Federal Poverty Level- \$148.00**
- **up to 500% of Federal Poverty Level- \$170.00**
- **over 500% of the Federal Poverty Level- \$269 (average bluecross indemnity rate)**

(rates above for clinic visits include NYS surcharge)

Clinic Visits (FQHC sites: CFCC, CHCC, MFHC, West Farms, University Avenue, and Prospect (South Bronx, Health Center)

- up to 100% of Federal Poverty Level - \$0
- up to 125% of the Federal Poverty Level - \$20
- up to 150% of the Federal Poverty Level- \$30
- up to 175% of the Federal Poverty Level- \$40

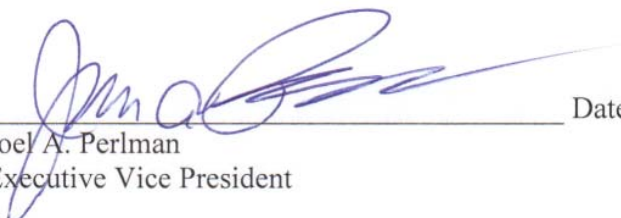
- up to 185% of the Federal Poverty Level- \$50
- up to 200% of the Federal Poverty Level- \$60

Medically Necessary Procedures- Ambulatory

- **up to 100% of Federal Poverty Level - \$150/ admission or procedure**
- **100% to 150% of the Federal Poverty Level- \$200**
- **150% to 175% of the Federal Poverty Level- \$497.00 (25% of average Medicaid rate)**
- **175% to 185% of the Federal Poverty Level-\$844.00 (50% of average Medicaid rate)**
- **185% to 200 % of the Federal Poverty Level- \$1,491.00 (75% of average Medicaid rate)**
- **200% to 300%% of the Federal Poverty Level - \$1988.00 (average Medicaid rate)**
- **300%-500% of Federal Poverty Level – Blue Cross Indemnity Rate**
- **Over 500% of Federal Poverty Level- Highest contracted rate**

Amounts above are fees prior to surcharge

Any patient having an MRI test that is below 100% of FPL will be responsible for \$150/procedure
All decisions can be appealed within 30 days of decision by providing proof of monthly income, monthly expenses, and a recent bank statement.

Approved by:  Date: 12/2/11
Joel A. Perlman
Executive Vice President