

SUBJECT: FINANCIAL ASSISTANCE POLICY (FAP)

PURPOSE

This Financial Assistance Policy outlines the process for provision of uncompensated and the uninsured to qualified patients.

POLICY

It is the policy of Calvary Hospital to inform every patient of the availability of Financial Assistance, defined as free or reduced healthcare services to the poor or indigent based upon their ability to pay and lack of insurance coverage. This policy will be uniformly applied to all patients who request such consideration based on financial need for NY State Residents. The amount of financial assistance granted will not be based on the medical condition of the applicant.

This policy shall apply only to medically necessary supplies and services provided by the hospital.

A copy of this policy and plain language of this policy can be found on the hospital website at www.calvaryhospital.org/patients-families/patient-financial-information/.

SUBJECT: FINANCIAL ASSISTANCE POLICY (FAP)

PROCEDURE

Uninsured patients, or patients who have exhausted their health insurance benefits, who present for services will be referred to the Cashier located in the Finance Department for financial screening. Signs are posted in all registration areas with contact information to assist patients who are unable to pay. Also, notification of this policy and contact phone number 718-518-2000 x2048 (Patient Accounts Department) is located on the patient's bill.

A. Notification

Each person requesting Calvary's services must be made aware of Calvary's Financial Assistance Policy (FAP) as follows:

1. Distribute an individual notice to each person who is seeking services on behalf of himself or another. This notice is passed to the individual usually at the point of admission or registration when financial arrangements are being discussed. The "Notice of Availability for Financial Assistance" is updated annually.(See Exhibit I).
2. Signs are posted conspicuously in the Admitting Office, Business Office, Clinic and Home Health Agency areas. The signs are to be in English, Spanish and Russian. Paper copies of the policy are available in several languages. In addition, Calvary has access to a language telephone service that adds additional languages.
3. Post both the FAP Policy and the FAP Policy in plain language, on the Hospital's website in English, Spanish and Russian. This information can be found at <http://www.calvaryhospital.org/patients-families/patient-financial-information>.

B. Eligibility

Persons are eligible for Financial Assistance if they:

1. Are not covered or receive services not covered under a third-party insurer of government program or have patient responsible amounts under third party insurers.
2. Have an annual family income of not more than 300% of the national poverty income guidelines.
3. Request services within the facilities program service plan.

All patients will be required to apply for Medicaid as a condition before receiving Financial Assistance. Failure to cooperate with the Medicaid application process may result in denial of Financial Assistance. Cooperation with the application and complying with Medicaid

requirements, as could reasonably be expected, to make themselves eligible (e.g., information support, “spend downs”, etc.).

All uninsured patients are presumptively eligible for the lowest level of discount available under the Discount Table provided by Calvary Hospital (including providers who are employed by or contracted directly by Calvary Hospital) until a full Medicaid application is submitted.

Calvary Hospital will provide emergency medical care within the guidelines of the Rapid Response Policy (see Nursing policy B.19 Rapid Response) without discrimination, whether or not the individuals are FAP eligible.

Services For Which Financial Assistance Is Available Under This Policy

Medically necessary services provided by physicians and other health care providers who treat you at Calvary Hospital whether employed by or directly contracted by the hospital are eligible. All listed provider services are covered under this policy except for Dr. Burger who although contracted with Calvary Hospital bills for his own services and therefore his services are not included in Calvary’s FAP policy.

A complete listing of Calvary employed providers or contracted Providers can be found on the Calvary website: www.calvaryhospital.org/patients-families/patient-financial-information/.

Eligibility Period

If a patient is approved for financial assistance under this policy, such eligibility shall remain in effect for one (1) year from the approval date of the application.

C. Determination of Eligibility for Financial Assistance

1. The patient will be screened for potential Medicaid and/or Medicaid Managed Care. If the patient is deemed eligible for any of the above, the patient will also be provided an application for financial assistance and the hospital will not pursue collections during the application process.
2. Determination can be made either before, during, or after the episode of care. In order to determine Financial Assistance, the patient will need to request an application within 240 days after discharge. Applicants must return a signed application with the supporting documents as described in the application within 20 days of the date of request. Calvary Hospital reserves the right to extend this period on a case-by-case basis:

Effective Date: 6/1997

Authorized By: Andrew V. Greco; Paulette M. Di Napoli

Revision Date: 4/2000; 4/2002; 4/2003; 4/2004; 4/2005; 3/2006; 7/2007; 7/2014; 10/2014; 9/2015; 3/2016; 10/2016; 5/2017; 7/2017; 1/2018; 4/2018; 3/2019; 3/2020; 2/2021; 1/2022

Supporting documentation may include but not limited to the following:

- a. One month's Pay stubs / Unemployment checks / Compensation papers / Social Security checks/copy of award letter(s);
- b. A completed and signed Financial Assistance Policy Request Form;
- c. W2 form for the previous year and or tax return;
- d. Other documentation as requested.

Generally, the patient's family income must not exceed 300 percent of the most recent Federal Poverty level to qualify (for information on the Federal Poverty Guidelines visit <http://aspe.hhs.gov/poverty/>). Assistance will be based on, but not limited to, family size and household income. Additionally, reviews of requested documents must provide indication that no other sources of income are available. When determining the FAP eligibility the Hospital will not consider a patient's primary residence or other assets.

The following sliding Scale will be utilized to determine the level of Financial Assistance (based on the Federal Poverty Guidelines):

100% write off at household income level under 200%;
90% write off on incomes over 201% and up to 250%;
85% write off on incomes over 251% and under 300%.

3. Upon receipt of all requested documentation, the Patient Accounts Director or Patient Accounts Manager will make a final determination as to the patient's Financial Assistance status within seven days. If all requested documentation is not received the patient will not qualify. Calvary Hospital does not do presumptive eligibility for our patients. During this determination period the patient's account will be placed on a bill hold.

The Patient Accounts Director or Patient Accounts Manager will make an initial determination as to whether the patient qualifies for free or reduced cost services based on personal interviews and or any preliminary documentation submitted. At the point that the Financial Assistance Policy application is approved the balance will be adjusted using the amounts generally billed (AGB) Prospective Method.

Qualified Patient Account Balances are adjusted to the amount generally billed (AGB) first and then the financial aid discount is applied if applicable. A Financial Aid (FAP) qualified individual will not be billed more than the amount generally billed (AGB).

AGB Summary 2022

- Inpatients – reduction of gross charges to the current Medicare TEFRA payment of \$1,449.00 per day (current 2022 rate, rate subject to change);
- Outpatients – reduction of gross charges to the average 2022 OPSS Medicare rate as shown below or the most current OPSS rate:

Clinic Visit	G0463	\$143.96
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- Physician Charges – reduction of gross charges to the 2022 Medicare rates as shown below or the most current Medicare Fee Schedule:

Level 1	99231	\$ 44.83
Level 2	99232	\$ 84.49
Level 3	99233	\$121.19
Admit	99221	\$122.22
Admit	99223	\$235.56
Discharge	99238	\$ 85.08

- Hospice – reduction of gross charges to the current Hospice Medicare rates as shown below:

Oct 2021-Sept 2022	BX/NY/QNS/WES/ ROC/ KINGS	Nassau
Routine Day 1-60	\$248.88	\$241.58
Routine Day 61+	\$196.68	\$190.91
SIA (SN/ MS visits during the last 7 days of life)	\$76.34/hr	\$73.87/hr
Continuous Care	\$1,835.14/24hrs	\$1,775.31/24hrs
Respite	\$571.66	\$555.94
General Inpatient	\$1,300.62	\$1,263.66

- Home Care – reduction of gross charges to the current Home Care Medicare rates as shown below:

2022	SN	PT	OT	ST	MSW	HA
	\$153.84	\$168.51	\$169.31	\$182.77	\$246.58	\$69.66/vst

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		200% FPL 100%	250% FPL 90%	300% FPL 85%
Inpatient (per day)	\$1,449.00	\$0.00	\$144.90	\$217.35
Clinic	\$143.96	\$0.00	\$14.40	\$21.59
Physician				
99231	\$44.83	\$0.00	\$4.48	\$6.72
99232	\$84.49	\$0.00	\$8.45	\$12.67
99233	\$121.19	\$0.00	\$12.12	\$18.18
99221	\$122.22	\$0.00	\$12.22	\$18.33
99223	\$235.56	\$0.00	\$23.56	\$35.33
99238	\$85.08	\$0.00	\$8.51	\$12.76
Hospice				
BX/NY/QNS/WES/ROC/KINGS County				
Routine Day 1-60	\$248.88	\$0.00	\$24.89	\$37.33
Routine Day 61+	\$196.68	\$0.00	\$19.67	\$29.50
SIA (SN/MS visits during the last 7 days of life) per hour	\$76.34	\$0.00	\$7.63	\$11.45
Continuous Care (every 24 hours)	\$1,835.14	\$0.00	\$183.51	\$275.27
Respite	\$571.66	\$0.00	\$57.17	\$85.75
General Hospice Inpatient	\$1,300.62	\$0.00	\$130.06	\$195.09
Nassau County			\$-	\$-
Routine Day 1-60	\$241.58	\$0.00	\$24.16	\$36.24
Routine Day 61+	\$190.91	\$0.00	\$19.09	\$28.64
SIA (SN/MS visits during the last 7 days of life) per hour	\$73.87	\$0.00	\$7.39	\$11.08
Continuous Care (every 24 hours)	\$1,775.31	\$0.00	\$177.53	\$266.30
Respite	\$555.94	\$0.00	\$55.59	\$83.39
General Hospice Inpatient	\$1,263.66	\$0.00	\$126.37	\$189.55
Home Care				
Skilled Nursing	\$153.84	\$0.00	\$ 15.38	\$ 23.08
Physical Therapy	\$168.51	\$0.00	\$ 16.85	\$ 25.28
Occupational Therapy	\$169.31	\$0.00	\$ 16.93	\$ 25.40
Speech Therapy	\$182.77	\$0.00	\$ 18.28	\$ 27.42
Social Worker	\$246.58	\$0.00	\$ 24.66	\$ 36.99
Home Aid per visit	\$69.66	\$0.00	\$ 6.97	\$ 10.45

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Patients who are underinsured or do not meet the criteria to qualify for financial assistance as noted above may be considered for assistance on a case-by-case basis.

4. A written determination of eligibility in response to each request for financial assistance is required and must be responded to within seven (7) working days of the request.
5. In the event that a patient has been referred to a collection agency prior to requesting assistance, the agency will refer the patient to the Hospital's Cashier for application processing. At that time the patient's account will be recalled from the agency.

D. Payments and Appeals

1. Additionally, the patient's ultimate responsibility can be paid in monthly installments, interest free, to Calvary Hospital. Installment payments will not exceed 24 months without Administrative approval or unless each monthly payment amount exceeds 10% of the patient's gross monthly household income.
2. For unfavorable determinations the outstanding balances will be pursued via the hospital's billing and collection policy, which may include referrals to collection agencies. The collection agency will pursue an estate search and assets from the patient's estate. Collection agencies must obtain Hospital approval in writing before any legal action is initiated. A copy of the hospital "Billing and Collection Policy" is available by calling the Patient Accounts Department Manager at 718-518-2064 or via Calvary Hospital web site: www.calvaryhospital.org/patients-families/patient-financial-information/
3. A patient may appeal the Hospital's decision regarding the denial of Financial Assistance. Appeals are to be directed to the Director of Patient Accounts, Calvary Hospital, 1740 Eastchester Rd., Bronx, NY 10461 for review. A final decision will be made within 2 weeks of the request.
4. The Hospital will periodically measure its compliance with this policy through an internal audit.

E. Responsibility

1. The CEO is responsible for assuring that Calvary Hospital fulfills its stated mission regarding the provision of Financial Assistance.
2. The Chief Financial Officer is responsible for overall control of the Financial Assistance Policy at Calvary.

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Exhibit I

NOTICE OF AVAILABILITY FOR FINANCIAL ASSISTANCE

Calvary Hospital, Inc. is required by law to give a reasonable amount of its services, without charge, to eligible persons who cannot afford to pay for care. Patients may be required to apply for Medicaid as a condition before receiving financial assistance. Failure to cooperate with the Medicaid application process, if requested, may result in denial of financial assistance. Eligibility for free or discounted care will be limited to persons whose family income is not more than 300% the current poverty income guidelines established by the Department of Health and Human Services. At Calvary Hospital, Inc., financial assistance is available to Inpatient, Outpatient Clinic, Physician, Home Health Care, and Hospice patients.

To be eligible to receive financial assistance, your annual family income must be less than 300% the Annual Poverty Income Guidelines:

<u>Size of Family</u>	<u>300% Annual Poverty Income Guidelines</u>
1	\$38,640
2	\$52,260
3	\$65,880
4	\$79,500
5	\$93,120
6	\$106,740
7	\$120,360
8	\$133,980

For each additional family member (over 8), add \$13,620

If you think you may be eligible for financial assistance, you may apply for them at the Admitting Department, Patient Accounting Department, Outpatient Clinic, or Home Care/Hospice Departments or call 718-518-2000 x2048. Calvary Hospital will make a written conditional or final determination of your financial assistance eligibility within seven (7) working days of receiving your request.

For a copy of the full Financial Assistance Policy, please visit our website at: www.calvaryhospital.org/patients-families/patient-financial-information/.

Effective: January 1, 2022

DEFINITIONS

Income: For purposes of determining financial eligibility under the Financial Assistance Policy, income includes total annual cash receipts before taxes from all sources. Income includes self-employment, social security payment, unemployment compensation, veteran's payments, public assistance, alimony, child support, private pensions, government pensions, insurance and annuity payments. Calvary Hospital accepts the following as proof of income:

- W2 forms
- Tax returns
- Social Security income
- Pension income
- Disability income

Income does not include the following types of money received: Capital gains, any assets drawn down as withdrawals from a bank, the sale of property, a house, a care, tax refunds, gifts, loans, lump-sum inheritances, one time insurance payments or compensation for injury. Also excluded are non-cash benefits, such as the employer paid or union paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied non-farm or farm housing, and such Federal non cash benefit programs as Medicare, Medicaid, food stamps, school lunches and housing assistance.

Family: A family is a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family. For instance, if an older married couple, their daughter and her husband and two children, and the older couple's nephew all lived in the same house or apartment; they would all be considered members of a single family.

Unrelated individual: An unrelated individual is a person (other than an inmate of an institution) who is not living with any relatives. An unrelated individual may be the only person living in a house or apartment, or may be living in a house or apartment (or in group quarters such as a rooming house) in which one or more persons also live who are not related to the individual in question by birth, marriage, or adoption. Examples of unrelated individuals residing with others include a lodger, a foster child, a ward, or an employee.

Household: As defined by the Census Bureau for statistical purposes, a household consists of all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units (see next item), but only one household. Some programs, such as the Food Stamp Program and the Low-Income Home Energy Assistance Program, employ administrative variations of the "household" concept in determining income eligibility. A number of other programs use administrative variations of the "family" concept in determining income eligibility. Depending on the precise program definition used, programs using a "family" concept would generally apply the poverty guidelines separately to each family and/or unrelated individual within a household if the household includes more than one family and/or unrelated individual.

Family Unit: "Family unit" is not an official U.S. Census Bureau term, although it has been used in the poverty guidelines Federal Register notice since 1978. As used here, either an unrelated individual or a family (as defined above) constitutes a family unit. In other words, a family unit of size one is an unrelated individual, while a family unit of two/three/etc. is the same as a family of two/ three/etc.

If the definition of family provided above is used, it must be interpreted to include college students as follows: Students, regardless of their residence, who are supported by their parents or others related by birth, marriage, or adoption are considered to be residing with those who support them.



CODE: A.25

CALVARY HOSPITAL APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name: _____
 Last First Middle Initial

Address: _____
 Street City State Zip Code

Type of Service Rendered/Requested: Inpatient Outpatient Physician Home Care Hospice

Date(s) of Service: _____

Applicant Statement:

I certify that the above information is true and accurate to the best of my knowledge. Further, if requested, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can judge my eligibility for uncompensated services based on the established criteria on file in the hospital. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

_____ Date Applicant's Signature

_____ Relationship Print Name

ELIGIBILITY DETERMINATION (FOR OFFICE USE ONLY)

Date Application Received: _____ Income Verified: Yes No

Med Rec #:	Last 12 Months	Last 3 Months	Family Size
Patient's Gross Income	_____	_____	_____
Other Family Income	_____	_____	_____
Total Family Income	_____	_____	_____

The Applicant is eligible for free care under or a reduction of _____ % of the hospital charges in accordance with our sliding scale. Amount provided as uncompensated services: _____.

Applicant's request for free services has been denied for the following reason(s): _____

_____ Date of Determination of Eligibility

_____ Date Applicant Notified

_____ Approved by Manager of Patient Accounts

The following documents were provided to verify income and family composition:

_____ Alternate Approved by Director of Patient Accounts

Paycheck Stub Income Tax Form
 Other: _____



CODE: A.25

Name
Address
City, St Zip

Dear _____,

Calvary Hospital, Inc. has conducted an eligibility determination for financial assistance for _____.

The request for financial assistance was received by Calvary Hospital _____. As required by the applicable regulation, this determination was completed on _____ which is within seven (7) working days following the receipt date of the request for financial assistance.

Based on the information supplied by the patient, or on behalf of the patient and in accordance with Calvary Hospital's Financial Assistance Policy, the following determination has been made:

- Conditional determination approved pending verification of income.
- Conditional determination approved, pending outcome of Medicaid Determination. Failure to comply with Medicaid application can result in denial of Financial Assistance.
- The applicant is eligible for a reduction of ____% of netted hospital charges* in accordance with our sliding scale. The applicant will be responsible for \$_____.
- The applicant's request for financial assistance has been denied for the following reason(s):
 - Applicant's income exceeds the income criteria.
 - Other _____

The Applicant can appeal the adverse decision by contacting the Director of Patient Accounts at (718) 518-2000 x2064. If your appeal is unsuccessful or, if you do not agree with the decision; you may contact the NYS Department of Health at (800) 804-5447.

If you have any questions on this determination, please contact Paulette M. Di Napoli at (718)518-2000 x 2048.

Sincerely,

Paulette M. Di Napoli
Patient Accounts Director

* Netted hospital charges reflect a reduction of hospital charges to the Medicare reimbursement rate prior to applying the financial assistance discount.