CALVARY HOSPITAL
Where Life Continues

SUBJECT/TITLE:
FINANCIAL ASSISTANCE POLICY (FAP)

DEPARTMENT/SCOPE: **ADMINISTRATIVE**

POLICY No.: **A.25**

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/.

PROCEDURE

Uninsured patients, or patients who have exhausted their health insurance benefits, who present for services will be referred to 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 718-518-2048 (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 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 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 400% 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.
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 30 days of the date of request. Calvary Hospital reserves the right to extend this period on a case-by-case basis:

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 400 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%;
80% write off on incomes over 301% and under 350%;
75% write off on incomes over 351% and under 400%.

3. Upon receipt of all requested documentation, Patient Accounts Management 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 Management 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 2025

- Inpatients – reduction of gross charges to the current Medicare TEFRA rate of $1,328.00 per day (current 2025 rate, rate subject to change);

- Outpatients – reduction of gross charges to the average 2025 OPPS Medicare rate as shown below or the most current OPPS rate:

Clinic Visit	G0463	$128.87

- Physician Charges – reduction of gross charges to the 2025 Medicare rates as shown below or the most current Medicare Fee Schedule:

99221	$90.15
99222	$141.33
99223	$188.00
99231	$53.07
99232	$85.88
99233	$127.61
99234	$105.38
99235	$171.24
99236	$223.89
99238	$88.27

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

Oct 2024-Sept 2025	**BX/NY/QNS/WES/ ROC/ KINGS**	**Nassau**
Routine Day 1-60	$295.11	$284.62
Routine Day 61+	$232.44	$224.18
SIA (SN/ MS visits during the last 7 days	$88.60/hr	$85.46/hr

of life)		
Continuous Care	$2,126.50/24hrs	$2,050.92/24hrs
Respite	$681.57	$657.35
General Inpatient	$1,537.20	$1,482.56

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

2025	SN	PT	OT	ST	MSW	HA
	$153.84	$168.51	$169.31	$182.77	$246.58	$69.66/vst

		200% FPL	**250% FPL**	**300% FPL**	**350% FPL**	**400% FPL**
		100%	**90%**	**85%**	**80%**	**75%**
Inpatient (per day)	$1,328.00	$0.00	$132.80	$199.20	$265.60	$332.00
Clinic	$128.87	$0.00	$ 12.89	$ 19.33	$ 25.77	$ 32.22
Physician						
99221	$90.15	$0.00	$ 9.02	$ 13.52	$ 18.03	$ 22.54
99222	$141.33	$0.00	$ 14.13	$ 21.20	$ 28.27	$ 35.33
99223	$188.00	$0.00	$ 18.80	$ 28.20	$ 37.60	$ 47.00
99231	$53.07	$0.00	$ 5.31	$ 7.96	$ 10.61	$ 13.27
99232	$85.88	$0.00	$ 8.59	$ 12.88	$ 17.18	$ 21.47
99233	$127.61	$0.00	$ 12.76	$ 19.14	$ 25.52	$ 31.90
99234	$105.38	$0.00	$ 10.54	$ 15.81	$ 21.08	$ 26.35
99235	$171.24	$0.00	$ 17.12	$ 25.69	$ 34.25	$ 42.81
99236	$223.89	$0.00	$ 22.39	$ 33.58	$ 44.78	$ 55.97
99238	$88.27	$0.00	$ 8.83	$ 13.24	$ 17.65	$ 22.07
Hospice						
BX/NY/QNS/WES/ROC/KINGS County						
Routine Day 1-60	$295.11	$0.00	$ 29.51	$ 44.27	$ 59.02	$ 73.78
Routine Day 61+	$232.44	$0.00	$ 23.24	$ 34.87	$ 46.49	$ 58.11
SIA (SN/MS visits during the last 7 days of life per hour	$88.60	$0.00	$ 8.86	$ 13.29	$ 17.72	$ 22.15
Continuous Care (every 24 hours)	$2,126.50	$0.00	$212.65	$318.98	$425.30	$531.63
Respite	$681.57	$0.00	$ 68.16	$102.24	$136.31	$170.39
General Hospice Inpatient	$1,537.20	$0.00	$153.72	$230.58	$307.44	$384.30
Nassau County						
Routine Day 1-60	$284.62	$0.00	$ 28.46	$ 42.69	$ 56.92	$ 71.16
Routine Day 61+	$224.18	$0.00	$ 22.42	$ 33.63	$ 44.84	$ 56.05
SIA (SN/MS visits during the last 7 days of life per hour	$85.46	$0.00	$ 8.55	$ 12.82	$ 17.09	$ 21.37
Continuous Care (every 24 hours)	$2,050.92	$0.00	$205.09	$307.64	$410.18	$512.73
Respite	$657.35	$0.00	$ 65.74	$ 98.60	$131.47	$164.34

General Hospice Inpatient	$1,482.56	$0.00	$148.26	$222.38	$296.51	$370.64
Home Care						
Skilled Nursing	$153.84	$0.00	$ 15.38	$ 23.08	$ 30.77	$ 38.46
Physical Therapy	$168.51	$0.00	$ 16.85	$ 25.28	$ 33.70	$ 42.13
Occupational Therapy	$169.31	$0.00	$ 16.93	$ 25.40	$ 33.86	$ 42.33
Speech Therapy	$182.77	$0.00	$ 18.28	$ 27.42	$ 36.55	$ 45.69
Social Worker	$246.58	$0.00	$ 24.66	$ 36.99	$ 49.32	$ 61.65
Home Aid per visit	$69.66	$0.00	$ 6.97	$ 10.45	$ 13.93	$ 17.42

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 thirty (30) 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 5% 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 at 718-518-2048

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.

Reviewed/Revised Date	Authorized By
6/1997; 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; 1/2023; 2/2024; 5/2025	CEO/CFO/Director Patient Accounts

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Calvary Hospital Financial Assistance Application Enclosed

Enclosed is the Financial Assistance Application, please complete the enclosed application in its entirety and return the completed application within 30 days to:

Calvary Hospital
1740 Eastchester Road
Bronx, NY 10465

Attn: Patient Accounts, Financial Assistance

After all items are received, your request will be reviewed and you will be notified in writing of your determination within thirty (30) days.

IMPORTANT

- ***No documentation to show proof of income or paid medical expenses is required when submitting this application***

If you have any questions, please do not hesitate to reach us at 718-518-2048.

Sincerely,

Financial Counseling Services

NYS Uniform Hospital Financial Assistance Application

You may be eligible for hospital financial assistance to pay your bills if you are uninsured, if your insurance is exhausted, or if you have health insurance but have proof of paid medical expenses totaling more than 10% of your income. Completing this form will start your request for hospital financial assistance. This form is used by all hospitals in New York State.

This application must be printed in the primary[1] languages spoken by patients served by the hospital.

Patient Name (complete information that is applicable)

Patient Name (First, Middle, Last)		
Date of Birth (mm/dd/yyyy)		
Address	Apartment/Unit #	
City	State	Zip
Contact Phone #		
Parent/Guardian or Lawful Representative Name (if patient is a minor child or an incapacitated adult)		
Email Address (if any)		

Family Information:
Please list below all family members in your household. Your household includes yourself, your spouse or domestic partner, and any children or other dependents. For example, this would include everyone listed on the same tax return.

Gross income means your income **before** taxes are deducted.

Gross income can consist of work earnings (wages, salaries, tips, earnings from self-employment), unearned income (social security, disability, and unemployment benefits), contributions (funds from family or friends), and other sources of income (temporary assistance and supplemental security income).

Full Name	Relationship	Total Gross Income (Current)
	Self	

[1] "Primary languages" includes any language that is used to communicate in at least 5% of patient visits per year, or any language spoken by more than 1% of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems.

The hospital may request you submit documentation as proof of income; examples of documentation might include a pay stub, a letter from your employer if applicable, or Form 1040.

Health Insurance Status

Do you have any form of health insurance, including Medicaid, Medicare, or private insurance through your employer or purchased on your own? ☐ Yes ☐ No

If you answered "No," would you like assistance in applying for any of these programs?

☐ Yes ☐ No

Underinsured patients: people with insurance and high medical expenses. If you have insurance, please provide an estimate of the medical bills you paid in the past 12 months.

$

The hospital may request you submit documentation as proof of paid medical expenses.

Patient/Responsible Party: If not the patient, list the name of the person signing the form and their authority to sign on behalf of the patient (e.g., spouse, parent, legal representative).

I understand that the information I submit may be subject to verification from external sources. I certify that the information is true and complete to the best of my knowledge.

Print Name Relationship to Patient	Date
Signature	

Minimum Eligibility and Guidelines

Application Timeline, Patient Rights, and Confidentiality

- You can apply for financial assistance at any point during the collection process.
- You do not have to make any payment to this hospital until you receive a decision on your application for financial assistance. Hospitals may not forward accounts to collection while your application is pending.
- If you are denied financial assistance, you have the right to appeal. Information on how to do so will be included in the hospital's notice you receive. You may have the right to appeal the amount of your financial assistance. The hospital will include information about how to appeal in their decision letter.
- Hospitals cannot send unpaid bills to a collection agency for at least 180 days after your first bill.
- Hospitals are prohibited from taking legal action, including filing lawsuits, to recover unpaid medical bills for patients below 400% of the federal poverty level. Poverty guidelines can be found here: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
- Any information provided in this application will only be used by the hospital to determine your eligibility for financial assistance and will remain confidential to the extent permitted by law.
- A hospital cannot deny you medically necessary services because you have an outstanding medical bill.
- If you need assistance with this application, please contact **Calvary Hospital, Inc**. financial assistance office at **718-518-2048.**
- If you need additional assistance with this application or help appealing a decision, you can reach out to Community Health Advocates: 888-614-5400.

Eligibility

Nothing limits a hospital's ability to establish patient eligibility for payment discounts at income levels higher than those specified below and/or to provide greater payment discounts for eligible patients than those required by Public Health Law. Additionally, immigration status shall not be an eligibility criterion for the purpose of determining financial assistance.

The following individuals are eligible:

- Low-income individuals without health insurance; or
- underinsured individuals (out-of-pocket medical costs accumulated in the past twelve months that amount to more than ten percent of such individual's gross annual income); or
- those who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges; or
- at the hospital's discretion, individuals who can demonstrate an inability to pay their co-pay and/or deductible can request a reduced or discounted payment.

Individuals up to 400% of the federal poverty level are eligible for financial assistance.

Federal Poverty Levels (2025)			
Household Size	**200%**	**300%**	**400%**
1 Person	$31,300	$46,950	$62,600
2 Persons	$42,300	$63,450	$84,600
3 Persons	$53,300	$79,950	$106,600
4 Persons	$64,300	$96,450	$128,600
5 Persons	$75,300	$112,950	$150,600
6 Persons	$86,300	$129,450	$172,600
7 Persons	$97,300	$145,950	$194,600

Updated annually: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Minimum Discount Rates

If you qualify for financial assistance, your charges will be reduced according to your income on a sliding fee scale as follows:

Income Level	**Payment**
Below 200% FPL	Waive all charges
200% - 300% FPL	Uninsured patients: Sliding scale up to 10% of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 10% of the amount that would have been paid pursuant to such patient's insurance cost sharing.
301% - 400% FPL	Uninsured patients: Sliding scale up to 20% of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 20% of the amount that would have been paid pursuant to such patient's insurance cost sharing.

Hospitals may choose to provide greater discounts for eligible patients and/or offer payment discounts for patients at higher income levels.

Installment Plans

Installment plans are available to patients who are unable to pay the reduced rate all at one time. Monthly payments cannot exceed 5% of your gross monthly income and the rate of interest charged to the patient on the unpaid balance, if any, shall not exceed 2%.

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 thirty (30) 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) 518-2064. 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)518-2048.

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.

Request for Proof of Household Income

Please include the income information for the patient, their spouse, and any dependents (such as children). For example, this would include everyone on the same tax return (tax filer, spouse, and tax dependents) in the calculation of household income.

The following is a list of documents you can use to prove your income. You do not have to provide all these documents. You can also provide a statement of no household income if you have no income.

You may also provide the Eligibility determination page from the NY State of Health Marketplace. If you have this document, you do not have to provide any other income information listed below to the hospital.

If Household Receives:	**Amount per Month:**	**Applicant May Provide:**
Wages	$	Please provide one Paycheck Stub, or Letter from Employer on company letterhead, signed and dated, or most recently filed income tax return.
Social Security Payment	$	Copy of award letter/certificate, or correspondence from the U.S. Social Security Administration, or annual benefit letter. To request a copy of your Social Security benefit letter, call 1-800-772-1213 or visit www.ssa.gov.
Unemployment Compensation	$	Copy of award letter/certificate, or monthly benefit statement from NYS Department of Labor, or Copy of Direct Payment Card with printout, or Correspondence from the NYS Department of Labor, or Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us).
Disability Payment	$	Copy of award letter/certificate, or correspondence from Social Security Administration, or copy of annual benefit letter. To request a copy of your benefit letter, call 1-800-772-1213 or visit www.ssa.gov.
Workers Compensation	$	Copy of Award Letter or Check stub.
Alimony/Child Support	$	Copy of court order, or 3 months of cashed checks/receipts.
Dividends/Interest	$	Quarterly dividend statements or 1 month statements.
Other	$	Letter stating the amount of non-wage earnings (if any), such as rental income, cash for odd jobs, etc.
No Income	$0	Signed statement of no income.