FINANCIAL ASSISTANCE PROGRAM

January 1, 2007
Revised April 1, 2018

Policy: It is the policy of **Oneida Healthcare (OHC)** to provide financial assistance to patients who are low income, uninsured or under insured and do not otherwise have the ability to pay the full cost of their healthcare needs. Hospital financial assistance is not a substitute for employer sponsored, public, or individually purchased insurance.

Notification of the **financial assistance policy** will be posted at each registration site including but not limited to the hospital registration department, the emergency room, lab draw stations, physical therapy building, the Gorman building and at the clinics. Notification of the **financial assistance policy** will be identified on the first post discharge patient billing statement to all patient/guarantors who have an open balance with the hospital. Signage informing patients of the **financial assistance program**, in various languages, will also be posted at each registration intake area based on the sample language format from the New York State Department of Health. The **financial assistance** summary will be made available on the hospital's website.

1. Approval for financial assistance will be based on a case by case basis.
   Determination will be made relative to household size and income level.

2. Patients must complete an **Oneida Healthcare (OHC)** financial assistance application and provide the required verification of income sources:

   Required income items:
   Copies or attestations of the following information
   Current pay stubs for a two month period
   Copies of prior 3 months checking and savings account statement
   Alimony or child support documentation
   All other source of income
   Copies of current pension and/or social security check
   Most recent income tax return

3. Based on the information provided on the application, **OHC** will review criteria to identify if the patient may be eligible for NYS medicaid coverage. If the information provided appears to meet eligibility guidelines, the patient

will be required to apply for NYS medicaid to obtain NYS medicaid approval or denial before the financial assistance determination will be made.

4. If **OHC** is unable to make a determination based on information provided, a letter will be sent to the patient advising the application is pending until complete information/documentation is received. This must be returned in a timely manner and as specified by **OHC** in order that an expeditious determination be made.

5. In the event it is necessary for a patient to apply for Medicaid and Medicaid denies based on failure to complete an application or refusal to comply with any conditions of eligibility this will result in the application for Financial Assistance being denied.

6. Account balances as a result of out of pocket expenses, benefits exhausted and denied insurance payment are eligible for financial assistance.

7. Cosmetic and/or elective surgery considered not medically necessary (for example; tubal ligation, vasectomy, etc) services are not eligible for financial assistance.

8. Application for financial assistance must be made within 120 days (notification period) from the first post discharge patient billing statement. Thereafter, all supporting and any additionally requested documentation upon timely notification, must be received by the facility within the timeframes requested by the facility not to exceed an additional 120 days (application period).

9. The financial assistance approval will be valid for those accounts listed on the application only. Approval of financial assistance will be honored for a 6 month period; therefore, reducing the necessity for “re-application”. However, if the financial status of a patient/guarantor has changed; **Oneida Healthcare** will ask the patient/guarantor to re-apply.

10. Determination of the financial assistance award will be made by business office personnel. The application will then be given to the Director of Patient Accounts or Business Office Supervisor for final approval. In cases where the account balances total greater than $15,000.00, approval of the Chief Financial Officer will be required.

11. Patients who have made application for financial assistance will receive a written determination from the Business Office within 30 working days of determination.

12. Patients who do not agree with the determination of eligibility for financial assistance may call the New York State Department of Health complaint hotline at 1-800-804-5447.

13. Financial assistance requests will not be honored until the final patient responsibility is determined after all insurances have paid their contracted portion. Any insurance disputes must be settled before the account balance will be considered.

14. The allowance for the financial assistance adjustment based on the 2018 federal poverty levels will be as follows:

Percent Income to Poverty Level

Household Size	100%		133%		150%		200%		250%		300%		400%
	At Least	Up To	At Least	Up To	At Least	Up To	At Least	Up To	At Least	Up To	At Least	Up To	At Least & Greater Than
1	$12,140	$16,145	$16,146	$18,209	$18,210	$24,279	$24,280	$30,349	$30,350	$36,419	$36,420	$48,559	$48,560
2	$16,460	$21,891	$21,892	$24,689	$24,690	$32,919	$32,920	$41,149	$41,150	$49,379	$49,380	$65,839	$65,840
3	$20,780	$27,636	$27,637	$31,169	$31,170	$41,559	$41,560	$51,949	$51,950	$62,339	$62,340	$83,119	$83,120
4	$25,100	$33,382	$33,383	$37,649	$37,650	$50,199	$50,200	$62,749	$62,750	$75,299	$75,300	$100,399	$100,400
5	$29,420	$39,128	$39,129	$44,129	$44,130	$58,839	$58,840	$73,549	$73,550	$88,259	$88,260	$117,679	$117,680
6	$33,740	$44,873	$44,874	$50,609	$50,610	$67,479	$67,480	$84,349	$84,350	$101,219	$101,220	$134,959	$134,960
7	$38,060	$50,619	$50,620	$57,089	$57,090	$76,119	$76,120	$95,149	$95,150	$114,179	$114,180	$152,239	$152,240
8	$42,380	$56,364	$56,365	$63,569	$63,570	$84,759	$84,760	$105,949	$105,950	$127,139	$127,140	$169,519	$169,520
Sliding Scale Discount	100%	100%	89%	89%	79%	79%	69%	69%	59%	59%	49%	49%	0%

15. Once a favorable determination has been made, the patient/guarantor will be provided notification along with an explanation of the expected time frames to remit balances due. The patient/guarantor will be requested to sign an agreement and return it to **OHC** within 14 days.

16. When a guarantor/family has been approved for financial assistance the guarantor may pay the adjusted account balance(s) in full or if necessary can set up payment arrangements. Payment plan parameters are listed below.

Account balance under $100.00	6 months – 9 months maximum
$100.00 - $ 500.00	9 months – 12 months maximum
$ 501.00 - $ 1000.00	12 months maximum
$ 1001.00 - $ 3000.00	18 months maximum
$ 3001.00 - $5000.00	24 months maximum
Over $5000.00	Contact the Business Office for payment arrangements

Monthly payments will not exceed 10% of the guarantor/family gross income.

17. The New York State surcharge amount, if applicable, will be an additional charge to the final discounted account balance.

18. A financial assistance monthly accounting will be maintained indicating the patient name, account number, date of service, type of service, date of application, date of approval/denial, total charges, total balance due from patient, adjustment amount, zip code and adjusted patient balance.

19. Copies of the application, approval/denial, summary bill and any correspondence relative to the financial assistance application will be maintained on file for a period of 10 years.