FINANCIAL ASSISTANCE POLICY

Canton-Potsdam Hospital is a not-for-profit corporation, which renders medical care to all persons in need of such care, regardless of their ability to pay. With the high cost of health care, increased deductibles and the number of uninsured patients who choose to have service at our hospital, we want to stress that a hospital bill should never get in the way of receiving essential health care services.

Canton-Potsdam Hospital will provide financial assistance allowances for individuals who demonstrate that the cost of our services will create a financial hardship. Canton Potsdam Hospital will approve Financial Assistance on a case by case basis for catastrophic care (a documentation checklist is included.)

We are committed to treating all patients with compassion, confidentiality and cultural sensitivity, from the bedside to the billing office. We are committed to upholding the Hospital’s Mission Statement.

Canton-Potsdam Hospital offers income based financial assistance for hospital bills.
- Help is offered to patients up to 300% of the Federal Poverty level
- Services must be medically necessary and within the Hospital’s primary service area
- Help is available to all New York State residents who meet income criteria
- Applications must be completed within 20 days of the initial request for financial assistance
- Applications for financial assistance must be returned within 90 days of discharge date of service
- Patients may contact our Patient Financial Services Department at the phone number listed below for an application or ask to speak with a financial counselor.
  
  · (315) 261-5150

FINANCIAL ASSISTANCE DOCUMENTATION REQUIREMENTS

Identity (one of the following)
1. Driver’s License
2. United States Passport or Foreign Passport
3. Alien Registration Card/Work Authorization Card
4. Photo ID
Residence (one of the following)

1. Mortgage Payment Book
2. NYS Housing Book/Rent Receipt
3. Electric bill, Gas bill or telephone bill
4. Current Mail

Income (as many as applicable)

1. If Employed Weekly, Last 4 Pay Stubs/Bi-Weekly, Last 2 Pay Stubs
2. Last unemployment Check/Worker’s Compensation/NY State Disability Check
3. Prior Year Income Taxes if Self Employed
4. Last Social Security/SSI Check
5. Pension Check
6. Other: _______________________________________________________________

PATIENT FINANCIAL SERVICES/FINANCIAL COUNSELING

- Our staff will refer patients to the area facilitated enrollers.

- Determination of ineligibility for government funded health insurance may be required prior to being accepted for the Financial Assistance Program. Eligibility will be determined for low income patients who are less than 300% below the Federal Poverty Level and:
  - Are without health insurance
  - Have exhausted their health insurance benefits
  - Are unable to pay full charges
  - Have incurred co-insurance/deductible costs
  - Catastrophic care


- Canton-Potsdam Hospital reserves the right to deny benefits to patients who are not willing to provide the required financial documentation.

- It is mandatory that a person apply for Medicaid benefits prior to financial assistance consideration if it is deemed necessary based on income levels. If patients refuse to apply for Medicaid even though we determine they may be eligible based on current Medicaid guidelines, patients can still apply for financial assistance and are eligible to receive no more than 35% discount for incurred medically necessary services.

NOTIFICATION OF FINANCIAL ASSISTANCE

- CPH has posted signs distributed and approved by the Department of Health throughout all Patient Access areas to include the main hospital, Registration and ER areas, and offsite clinic areas.

- All Self-Pay Patients are made aware of the CPH Financial Aid Policy during the financial counseling process and/or at registration/point of service.
• The Patient is provided (upon request) with a “Financial Assistance Policy Patient Summary” letter, which outlines our policy for the patient.

**COVERED SERVICES**

• Financial assistance allowances are available for medically necessary traditional inpatient and outpatient services for patients who are residents of New York State. Emergency services for all low income uninsured residents of New York State, including those who are transferred according to EMTALA guidelines, will also be included in the Financial Assistance Program.

• Additional charges from the Radiologist, Ambulance transport, and Pathologist patients may receive, are NOT covered by this program.

• Penalties applied for failure to obtain a referral from a primary care physician or prior authorization required by the patient, will not be covered by financial assistance services. Services for out of network provider denials will be reviewed and decisions made on a case-by-case basis.

**BENEFIT/DISCOUNT ELIGIBILITY SCALES**

• As outlined in the Federal Guidelines, CPH is allowed, but not required, to offer discounts on patient deductibles, co-insurance, spend-downs, and co-payments.

• All balances left to patient responsibility will not be subject to the discounted rates offered to uninsured patients as described in this policy.

These balances will be considered by utilizing the following sliding fee scale:

**CPH SCHEDULE OF BENEFITS FOR CO-INS/DEDUCTIBLES/SPENDDOWNS/CO-PAYS**

<table>
<thead>
<tr>
<th>Percent of FPG/ Percent required from Patient</th>
<th>Percent of FPG/ Percent required from Patient</th>
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<tbody>
<tr>
<td>100-110% / 10%</td>
<td>151-160% / 20%</td>
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<tr>
<td>111-120% / 12.5%</td>
<td>161-170% / 28.5%</td>
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<tr>
<td>121-130% / 15%</td>
<td>171-180% / 37%</td>
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<tr>
<td>131-140% / 17.5%</td>
<td>181-190% / 45.5%</td>
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<tr>
<td>141-150% / 20%</td>
<td>191-200% / 54%</td>
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<td>201-210% / 62.5%</td>
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<td></td>
<td>211-220% / 71%</td>
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<td>221-230% / 79.5%</td>
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<td>231-240% / 88%</td>
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<td></td>
<td>241-250% / 96.5%</td>
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<td>251-300% / 98%</td>
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ALLOWANCE FOR UNINSURED BALANCES

The following scale details the financial assistance consideration given to patients who are uninsured and have incurred all charges without the financial assistance of an insurance carrier:

**CANTON – POTSDAM SCHEDULE OF BENEFITS BASED ON FEE CAP INCREMENTS FOR UNINSURED PATIENTS**

<table>
<thead>
<tr>
<th>Percent of FPG/Percent Reimbursement</th>
<th>Percent of FPG/Percent Reimbursement</th>
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<tr>
<td>100-110% / 10%</td>
<td>151-160% / 20%</td>
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<tr>
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<tr>
<td></td>
<td>241-250% / 96.5%</td>
</tr>
</tbody>
</table>

**CAPS ON CHARGED FEES**

Maximum fees are determined based on the higher of:
* Medicare Rates
* Medicaid Rates, or rates paid by the highest volume commercial payer (contracted payer with highest claim volume at Hospital in prior year)

- CPH utilizes the Blue Cross contractual rate for the initial discount of charges for outpatient services. Inpatient services will be adjusted based on the DRG.
- CPH reserves the right to set different standards for different services.

**FEE CAPS BY PATIENT’S INCOME LEVEL**

<table>
<thead>
<tr>
<th>Income &lt;=100% FPG</th>
<th>101% - 150% of FPG</th>
<th>151% - 250% of FPG</th>
<th>251% - 300% of FPG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominal payment only according to Commissioner established guidelines</td>
<td>Sliding fee scale (= increments) up to 20% Medicare, Medicaid, or 3rd party rate</td>
<td>Sliding fee scale (= increments) up to Medicare, Medicaid, or 3rd party rate</td>
<td>No more than Medicare, Medicaid, or 3rd party rate</td>
</tr>
</tbody>
</table>
TIME CONSTRAINTS

- Patients requiring prior denial from Medicaid or other insurance who are seeking financial assistance will need to apply for Medicaid within 90 days of the service date.

- When applicable, Medicaid approval, denials or spend-down decisions must be provided to the Patient Financial Services Office in order to make a decision for financial assistance benefits.

- Patients have 90 days from date of service to apply for financial assistance, and at least 20 days to submit a completed application including all required documentation. Medicaid and Financial Assistance Applications will be processed concurrently to shorten the time required for a decision on financial assistance.

- When the Patient Financial Services representative receives the application, he or she will advise the patient of any missing information. CPH will allow fifteen (15) days for the patient to provide us with any missing information. If the financial assistance application is sent via mail, the Patient Financial Services representative will advise the patient via notification letter of the missing information.

- If the patient has health insurance coverage for the date of the service but failed to provide this information to CPH in a timely manner, eligibility for financial assistance will be null and void; however, appeals will be accepted and reviewed via the normal appeals process as outlined in this policy. CPH is under no obligation to approve these appeals, but will fairly review all reasons for initial non-compliance.

- If the additional information required is not received within the 15 days, the application will be denied for failure to comply/submit the required information and may be appealed.

- CPH will respond in writing with either approval, or denial within 30 days after receipt of completed application.

INDIGENCY CRITERIA

- While flexibility in applying guidelines to individual patient's financial situation is clearly needed, objective criteria are essential for consistent and reliable accounting treatment of financial assistance service and bad debts.

- Evaluation of the appropriate criteria in determining whether a patient is eligible for financial assistance services will be ongoing. This review is necessary for the Hospital to properly identify the extent of resources devoted to such services and at the same time exercise good stewardship in expending hospital resources.

- If criteria are narrow and restrictive, the goal of objective and consistent determination may be achieved at the individual patient's expense. If criteria are too broad and general, the classification bad debts or financial assistance services becomes highly subjective and the possibility of misclassification increases.

- Flexible guidelines have been established which allow the Hospital to exercise a reasonable degree of latitude in establishing eligibility for financial assistance. The guidelines include criteria for evaluating future, as well as, current ability to pay. In order to assure objectivity and consistent implementation of the financial assistance guidelines which are established, the Hospital will periodically review samples of patient accounts.
which have been accepted for financial assistance services. The hospital reserves the right to approve catastrophic services on a case by case basis.

**TRANSLATION SERVICES**

- Translation services will be provided to the patient upon request for completion of the application.

**REQUIRED DOCUMENTATION FOR APPLICATION PROCESS**

Patients are required to submit approved documentation confirming the following information:

In determining financial assistance eligibility, the Hospital will consider the following guidelines and factors:

The Application: (See “Application for Financial Assistance”)

- Proof of identification, residency, and employment information
- Income from all resources
- Resources from savings and checking accounts, certificates of deposit, stocks, bonds, real estate, etc.
- Number of dependents
- A copy of the most recent federal income tax forms, if self-employed

- If the patient is having a recurring service including multiple dates of service within one month, he or she may be required to have Medicaid screening prior to approval for the Fee Schedule reduction rates.

**ELIGIBILITY CRITERIA**

- Gross income will fall within established or recognized standards for determination of poverty level, considering family size, and other pertinent factors. (Some persons may exceed poverty income levels, but still qualify for financial services when additional criteria are considered.) As a general rule, a patient’s gross income must not exceed 300% of the federal poverty income guidelines.

- Net worth will be considered for 1099/self-employed including all liquid and non-liquid assets owned, less liabilities and claims against assets. As a general rule, net worth which could be used as collateral to obtain outside financing would disqualify an individual from obtaining a financial assistance allowance.

- Family size will be considered.

- The amount(s) and frequency of the hospital bill(s) in relation to all of the factors outlined above will be considered.

- All other resources will first be applied, including Medicaid and other third party resources.

- Write-off of only a portion of an account as financial assistance service will be considered in instances where the patient is able to pay part of the account, according to the above criteria, but is indigent in terms of paying the entire amount.
• Current documentation is required for the application process. The patient will be responsible for supplying the documentation within the time constraints defined. The Patient Financial Services representative will provide assistance when questions arise regarding documentation.

• If specific required documentation cannot be provided, a written or verbal explanation must be supplied as to why the documentation cannot be provided and will be notarized by the CPH leaders.

• Any additional information can be provided in writing and accompany the application to support your application for financial assistance.

APPROVAL / DENIAL PROCESS

• The Patient Financial Services representative will review the completed application and supporting documentation and forward it to the Director of Patient Financial Services or designee.

• The Director of Patient Financial Services or designee will review the application and process it according to the Federal Poverty Income Guidelines for the current year.

• The applicant will receive a “Decision of Financial Assistance” letter from the Patient Financial Services Department. The decision letter will advise the applicant of the final decision of approval or denial and the reasons within 30 days of receipt of completed application.

BALANCES ON ACCOUNTS AFTER FINAL DECISION

• If a balance is owed on the account after a financial assistance discount for a portion of the bill, the applicant will be required to agree to make monthly payments.

• Monthly payments will be set up on a written payment contract and the amount agreed upon must be received in a timely manner, in order for the contract to stay valid.

• Payment plans must not exceed 10% of the patient's monthly gross income.

COVERAGE PERIOD FOR THIS APPLICATION

• If application is completed and all necessary documentation is provided, the approval discount will be applied for a period of one year from the decision date on the application; however, the following will apply to this coverage period:

  I. If the financial situation of the household changes, the Patient Financial Services Department must be notified within 30 days of the change in circumstances.

  II. Applicants must agree to respond within 30 days to any correspondence from the Patient Financial Services representatives, if it is believed the financial situation has changed. Failure to do so will negate the remaining coverage period.

  III. Patient Financial Services may require additional proof of financial information during this covered period
PATIENT FINANCIAL SERVICES POLICY

- Monthly statements on the account will continue during the application and review process. Interest will continue to be applied unless a payment arrangement is made during the processing of the application, and the payments are received.

- Patients may disregard related bills sent by CPH if they have submitted a completed application and it is currently in the review process. Collection Agencies will NOT be involved during the application review process.

- If the application is not received in the time constraints listed and the account is turned over to the collection agency, the account will NOT be considered for financial assistance.

- Current balances previously submitted to our collection agency are not eligible for financial assistance.

INVolVEMENT OF COLLeCTION AGENCY

- If the payment contract is terminated due to failure to pay upon the agreed amount monthly, the account may be transferred to our collection agency for processing with 30 days written notification from Canton-Potsdam Hospital.

- This will occur when two missed payments occur without notification to the Patient Financial Services representative. Reasonable collection efforts will be exhausted by the Patient Financial Services representative, including phone calls and/or letters.

- Our first priority is to work with all patients to determine a mutual understanding that will work for both the Hospital and the patient.

- If the account is turned over to our collection agency, they may take further action in collection such as garnishment of wages or legal action.

- Legislation prohibits the forced sale or foreclosure of primary residence; however, liens are allowed to be placed on primary residence.

- CPH MUST provide written consent to the collection agency prior to the agency taking action against an account, and the agency MUST follow CPH’s Financial Assistance Policies and Procedures during the recovery process.

- Collection efforts may not be taken against patients eligible for Medicaid at the time services are rendered and CPH is able to collect payment from Medicaid.

APEAL PROCESS

- Appeals for financial assistance decisions must be received in the Patient Financial Services Department within 30 days from the date of the initial decision.
Denials received due to failure to comply/submit completed application or information will be subject to the appeal process. The appeal form is included with all financial assistance applications.

Appeals will be reviewed by the Director of Patient Financial Services or a designee for a final decision. Appeals will be reviewed and a decision will be made within 30 days of the date of receipt of the appeal.

STAFFING

- CPH will maintain adequate staffing levels, and provide updated training on procedures for patient interaction and the proper handling of billing and collection efforts regarding financial assistance. Staff will be monitored for quality based on internal CPH standards developed and implemented by Management.

CPH FINANCIAL REPORTING DUTIES

- CPH will be responsible for providing reports detailing the facility's involvement in the Financial Assistance Program. Reporting duties will include:
  
  a) Hospital costs/charges incurred  
  b) Uncollected amounts for services to the uninsured and the underinsured (including uncollected nominal payment, co-insurance, and deductibles)  
  c) Amount of distribution from the Indigent Care (BDCC) Pool  
  d) Amount spent from bequests or trusts established to provide financial aid  
  e) Number of patients who applied for aid  
  f) Application approvals and denials by zip code  
  g) Number of patients receiving assistance to apply for Medicaid (where applicable)  
  h) Number of liens placed on a patient's primary residence (where applicable)
Financial Assistance Application

Office Use Only:

Patient Account Number: _________________

Date of Application: ________________

**Patient Information:**

Patient Name: ___________________________ Date of Birth: __________
Guarantor: ________________________________
Address: __________________________________
Home Phone #: ____________________________ Cell Phone #: _________________________

**Employer Information:**

Name: ________________________________
Address: ________________________________
Phone #: ________________________________

**Spouse Information:**

Name: ________________________________
Employer: ________________________________
**Family Assets: (Indicate all that applies and include current balances)**

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
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<tbody>
<tr>
<td>Cash on Hand</td>
<td>$</td>
</tr>
<tr>
<td>Checking Account</td>
<td>$</td>
</tr>
<tr>
<td>Savings Account</td>
<td>$</td>
</tr>
<tr>
<td>Other - (Please specify)</td>
<td>$</td>
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<tr>
<td>Total</td>
<td>$</td>
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**Income: Indicate if you or anyone who lives with you receives money from:**

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
<th>How Often</th>
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<tbody>
<tr>
<td>Employment (Salary)</td>
<td>$</td>
<td></td>
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<tr>
<td>Self-Employment Income</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Social Security/Disability</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Unemployment/Worker's Comp. Benefits</td>
<td>$</td>
<td></td>
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<tr>
<td>Pension</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Dividends/Interest Income/Rental Income</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Income from other sources - (Please specify)</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Total monthly gross income from all sources</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>
### Household Members Information:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Date of Birth</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<td>7.</td>
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</table>

Is medical treatment because of a car accident or other third party injury? Yes _____ No _____

If yes, please explain: ______________________________________________________

Is medical treatment because of a work related accident or injury? Yes _____ No _____

If yes, please explain: ______________________________________________________

### Documentation Required:

#### Identification (one of the following)

5. Driver’s License
6. United States Passport or Foreign Passport
7. Alien Registration Card/Work Authorization Card
8. Photo ID

#### Residence (one of the following)

5. Mortgage Payment Book
6. NYS Housing Book/Rent Receipt
7. Electric bill, Gas bill or telephone bill
8. Current Mail

#### Income (as many as applicable)

7. If Employed Weekly, Last 4 Pay Stubs/Bi-Weekly, Last 2 Pay Stubs
8. Last unemployment Check/Worker’s Compensation/NY State Disability Check
9. Prior Year Income Taxes if Self Employed
10. Last Social Security/SSI Check
11. Pension Check
12. Other: _________________________________________________________________

Applying for Medicaid: Yes _____ No _____

Medicaid Approved: Yes _____ No _____
I hereby certify that the information provided for purposes of creating a Financial Assistance Application is correct to the best of my knowledge.

_______________________________________ Applicant Signature
_______________________________________ Date

_______________________________________ Parent/Guardian Signature
_______________________________________ Date