WYCKOFF HEIGHTS MEDICAL CENTER ADMINISTRATIVE
POLICY AND PROCEDURE MANUAL

CODE: 5.2

CATEGORY:	Revenue Cycle/Finance
SUBJECT:	Charity Care/Financial Assistance
ORIGINATOR:	Vali Gache, CFO
EFFECTIVE DATE:	October 20, 2024
REVIEW DATE:	10/3/2024
REVIEWER'S	Vali Gache
SIGNATURE:	

POLICY

Wyckoff Heights Medical Center will provide Charity Care and Financial Assistance to all qualifying patients for non-elective services and clinic visits. Eligibility will be based solely on the ability to pay and will not be based on age, sex, race, creed, disability, sexual orientation, or national origin. Full Financial Assistance will be limited to persons whose family income is not more than 100% of the current Federal Poverty guidelines. A sliding fee scale for Hospital-based services and flat fees for Clinic visits will be granted to families with resources up to 400% of the poverty level. Charity Care patients will be granted a percentage discount for extensive dental procedures or when a procedure is performed in the clinic. Special consideration will be given to patients with extenuating circumstances.

Wyckoff Heights Medical Center will not charge individuals eligible for charity care under this policy more than the amounts generally billed (AGB) to individuals with insurance covering such care. AGB is determined based on the Medicaid reimbursement rate.

You are encouraged to apply for financial assistance within 90 days from the first post-discharge date noted on the statement; however, you are permitted a minimum of 240 days to apply and submit a completed application.

The Hospital will widely publicize this policy by posting it on its website, providing paper copies, signage, and information in billing statements. https://whmcny.org/billing-payment/

DEFINITIONS:

Amounts Generally Billed (AGB)- means the amounts generally billed for Covered Services provided to individuals who have insurance covering such care, reduced to the current Medicaid rate using the prospective method. The prospective method means using the billing and coding process the Hospital would use if the FAP–Eligible Individual (as defined) were a Medicaid fee-for-service beneficiary and setting AGB for the care at the amount the hospital determines would be the total amount Medicaid would allow for the care.

HOSPITAL- means Wyckoff Heights Medical Center located 374 Stockholm St, Brooklyn, NY 11237

MEDICALLY NECESSARY- means those services necessary to prevent, diagnose, correct, or cure conditions in a person that cause acute suffering; endanger life; result in illness or infirmity; interfere with his/her capacity for normal activity; or threaten some significant handicap.

PROMPT PAY- means a discount may be applied to a patient's co-insurance, deductible, or other outstanding patient balance if the

patient agrees to pay the balance in full within 30 days of receiving their first statement. The discount is to encourage patients to pay their bills in a timely fashion. Patients with approved Charity Care or outstanding co-payments do not qualify for the prompt-pay discount.

RESPONSIBILITIES:
Director of Patient Accounts - will update the policy annually upon Federal Poverty Level publication, and intermittently (as needed) when DOH updates existing DOH policy.

SELF PAY PATIENTS
Wyckoff Heights Medical Center will limit its charges to individuals eligible for its Charity Care program to amounts generally billed (AGB) for emergency or other medically necessary care to individuals who have insurance. AGB is determined based upon the Medicaid reimbursement rate. Refer to the DOH Fee Schedule for further details.

https://www.health.ny.gov/health_care/medicaid/rates/apg/rates/hospital/hosp_base_rates.htm

https://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm

PRESUMPTIVE ELIGIBILITY FINANCIAL ASSISTANCE:
There are instances when a patient may appear eligible for Financial Assistance, but the formal application process and documentation requirements were not completed. For these cases, the Hospital may use outside sources of information from software vendors (Transunion, Change Healthcare etc.) to assist in estimating patient income to determine Presumptive Financial Assistance eligibility. Presumptive eligibility may be based on prior FAP Eligibility.

SPECIAL INFORMATION

Eligibility will be conditional on a person applying for local, state, federal, or other third-party assistance or insurance.

There are four (6) groups for reduction of charges, which are based on income and family size. Patients/guarantors will be responsible for paying a percentage of hospital-based charges (unless granted 100% charity for hospital services) or flat fee rates for Clinic visits:

CHARITY CARE *I* POVERTY INCOME GUIDELINE

	100%	125-150% of FPL		175-250% of FPL		275-400% of FPL MAX	
Family Size	Level 1 Maximum income limit	Level 2 Maximum income limit	Level 3 Maximum income limit	Level 4 maximum income limit	Level 5 maximum income limit	Sliding fee level 6 income range*	
1	$15,060	$18,825	$22,590	$26,355	$37,650	$41,415	$60,240
2	$20,440	$25,550	$30,660	$35,770	$51,100	$56,210	$81,760
3	$25,820	$32,275	$38,730	$45,185	$64,550	$71,005	$103,280
4	$31,200	$39,000	$46,800	$54,600	$78,000	$85,800	$124,800
5	$36,580	$45,725	$54,870	$64,015	$91,450	$100,595	$146,320
6	$41,960	$52,450	$62,940	$73,430	$104,900	$115,390	$167,840
7	$47,340	$59,175	$71,010	$82,845	$118,350	$130,185	$189,360
8	$52,720	$65,900	$79,080	$92,260	$131,800	$144,980	$210,880
For each addt'l person	$5,380	$6,725	$8,070	$9,415	$13,450	$14,795	$21,520

Family units with more than eight family members add $ 5,380 for each additional person
SOURCE: Foundation for Health Coverage Education; 2024 Federal Poverty Level

Outpatient vs. Inpatients Charity Referrals
Redefine process

Note: Based on the existence of extenuating circumstances, The Vice President of Revenue Cycle may approve the extension of charity care, at his discretion, to applicants who do not qualify based on income guidelines listed above.

Based on the balance of the amount requested to be adjusted/written-off, appropriate level of approval must be obtained:

Adjustment/Write off Balance	Approval Needed
<$2,500	Patient Access/Account Team Member
$2,501 - $20,000	Patient Access/Accounts
$20,001 - $50,000	Patient Access/Accounts
$50,001 - $100,000	Director, VP, Reimbursement and Revenue Cycle
$100,000+	Chief Financial Officer

PROCEDURE

1. The Patient/Guarantor must make requests in person or by phone 718-963-7317 or the Customer Service Area room 1-32 Medicaid Office.

2. A designated staff member interviews the Patient/Guarantor for any third-party coverage that would pay for service.

3. Discuss the Patient's financial situation and determine if they have the ability to pay. If a lump sum payment cannot be made, credit card(s) or an agreed upon payment plan is acceptable.
    a. If the patient can afford to pay, establish payment expectations with the patient to resolve the account(s).
    b. If the patient does not have coverage and cannot afford to pay
        1. Explain the charity program and requirements to the patient/guarantor
        ii. Explain the required supporting documentation that needs to accompany the application – Proof of identification, residency and income.
        iii. Provide the patient with a Charity Care application and request the application be completed within ten (10) working days.
        iv. If there are any unresolved questions, schedule a face-to-face meeting with the Patient/Guarantor.
        v. Inform the Patient/Guarantor that they will be notified of eligibility within ten (10) days of receipt of a completed application and necessary supporting documents.

4. Upon receipt of the application, a designated staff member will complete the review.
    a. If the application is incomplete or has not been received after fifteen (15) days from discussion:
        I. Call or mail a request to the patient stating they have ninety (90) additional days to complete the Charity Care application, or they will be processed as self-pay
        ii. If the patient is not cooperative, transfer or leave the account in self-pay.
        111. Document activity in the ALLSCRIPTS system
    b. If the application is complete with all required supporting documentation, review the application and approve or deny.
        i. If approved, determine the amount of charity to be granted based on the schedule below and go to next step 5.

FINANCIAL ASSISTANCE REDUCED FEE SCHEDULE

	100%	101-200% of FPL		201-300% of FPL		301-400% of FPL MAX	
Family Size	Level 1 Maximum income limit	Level 2 Maximum income limit	Level 3 Maximum income limit	Level 4 maximum income limit	Level 5 maximum income limit	Sliding fee level 6 income range*	
1	$15,060	$15,211	$30,120	$30,271	$45,180	$45,331	$60,240
2	$20,440	$20,644	$40,880	$41,084	$61,320	$61,524	$81,760
3	$25,820	$26,078	$51,640	$51,898	$77,460	$77,718	$103,280
4	$31,200	$31,512	$62,400	$62,712	$93,600	$93,912	$124,800
5	$36,580	$36,946	$73,160	$73,526	$109,740	$110,106	$146,320
6	$41,960	$42,380	$83,920	$84,340	$125,880	$126,300	$167,840
7	$47,340	$47,813	$94,680	$95,153	$142,020	$142,493	$189,360
8	$52,720	$53,247	$105,440	$105,967	$158,160	$158,687	$210,880
For each addt'l person add	$5,380	$5,434	$10,760	$10,814	$16,140	$16,194	$21,520
Inpatient	$0	$0	$0	10% of Medicaid Rate	10% of Medicaid Rate	20% of Medicaid Rate	20% of Medicaid Rate
Amb-Surg	$0	$0	$0	10% of Medicaid Rate	10% of Medicaid Rate	20% of Medicaid Rate	20% of Medicaid Rate
Observation	$0	$0	$0	10% of Medicaid Rate	10% of Medicaid Rate	20% of Medicaid Rate	20% of Medicaid Rate
Emergency Room	$0	$0	$0	10% of Medicaid Rate	10% of Medicaid Rate	20% of Medicaid Rate	20% of Medicaid Rate
Referred	$0	$0	$0	10% of Medicaid Rate	10% of Medicaid Rate	20% of Medicaid Rate	20% of Medicaid Rate
Chemotherapy	$0	$0	$0	10% of Medicaid Rate	10% of Medicaid Rate	20% of Medicaid Rate	20% of Medicaid Rate
Clinic	$0	$0	$0	10% of Medicaid Rate	10% of Medicaid Rate	20% of Medicaid Rate	20% of Medicaid Rate
Under Insured Co-Pays, Deductible & Coinsurance	$0	$0	$0	10% of Medicaid Rate	10% of Medicaid Rate	20% of Medicaid Rate	20% of Medicaid Rate

ii. If denied go to Step 5.

5. Complete a Charity Application Worksheet:
   a. Document situational/summary information
   b. If denied, check off denied, sign and date form. Go to step #9b c.

   If approved:
   i. Select Level# for approval and any condition that must be met ii.
   Sign and date top section of application
   d. If amount is within your approval limits, proceed to step #9a

e. If the amount is over your approval limits, date and sign the form, document activity in ALLSCRIPTS, and refer to the appropriate Manager

6. Manager reviews documentation and verify that due diligence steps were taken.
   i. If the balance is within the approval level return to team member who completed the worksheet and proceed to step #9a
   ii. If over the Manager's approval level, forward to the appropriate Director. Proceed to# 7

7. Director reviews Charity Care request
   1. If the balance is within the approval level, return the application to a staff member who completed the worksheet. Proceed to step #9a
   11. If the balance is over the approval level, forward it to the Vice President of Finance for approval.

8. If applicable, Vice President of Finance reviews the Charity Care request
   Sign and date the form, and return it to the Director who referred the worksheet. Proceed to step #9a.

9. The Patient Accounts department receives a worksheet with appropriate signatures and determination;
   a. If approved:
      i. Inform the patient/guarantor of the approval and the estimated self-pay portion that the patient will be responsible for. Emergency and medically necessary services cannot be denied for non-payment.
      ii. Notify the clinical department of financial Investigators of the determination for scheduled services.
      iii. Complete the adjustment form for any outstanding balances
      iv. Change financial class to Charity
      v. Document activity in the ALLSCRIPTS system.
      vi. Retain application as directed
   b. If denied:
      1. Inform the patient/guarantor of the denial and work with them to resolve the account
      ii. Notify the clinical department of financial Investigators of the determination for future services. iii. Document activity in the ALLSCRIPTS system.
      iv. Retain application as directed. v. Change to self-pay.

5. Collection Policy and Extraordinary Collection Actions (ECA): Wyckoff Heights Medical Center will make all reasonable efforts to determine eligibility and will follow collections processes in accordance with 501(r) regulations.

The following facilities are covered by this policy:
Wyckoff Heights Medical Center: Inpatient, emergency, outpatient, ambulatory care, ambulance and Faculty practice.
Private physician fees are not covered by our financial assistance policy.

Attachment:
Charity Care Application Charity Care Worksheet Form Financial Assistance Summary

Compliance Review:

Kevin Smyley

Approved:

Ramon Rodriguez, President & CEO

Wyckoff Heights Medical Center

374 Stockholm Street, Brooklyn, NY 11237

APPLICATION FOR CHARITY CARE/FINANCIAL ASSISTANCE

Name: _____

Address: _____

_____

Phone: _____

Family size/number in household: _____

	Patient Income Wkly Biwkly Mthly	Spouse Income Wkly Biwkly Mthly
Wages		
Social Security payment		
Unemployment compensation		
Disability		
Workers compensation		
Alimony/child support		
Dividends/interest/rentals		
All other income		
Total		

	Patient ASSETS	Spouse ASSETS
CHECKING ACCOUNT BALANCE		
SAVING ACCOUNT BALANCE		

I affirm that the above information is true, complete, and correct to the very best of my knowledge.

Signed_____ Date_____

If you have questions or need help completing this application, call Financial Counseling at 718-963-7317.

If you have received a bill or bills from the hospital, check here: _____

You do not have to make any payment to the hospital until the hospital sends you a letter with its decision on your application.

Please send completed form and attachments to:

Wyckoff Heights Medical Center
Financial Assistance Program, room 1·32
374 Stockholm Street
Brooklyn, NY 11237

374 Stockholm St. Brooklyn, NY 11237

MEDICAID DEPT. ROOM 1-32

Necessary Documents for Financial Assistance/Charity Care

IDENTIFICATION
All the following documents are required as proof of identification:

Birth Certificate or Passport (all family members)
Driver's License
Military Service Records (if applicable) Social
Security Card (all family members)

RESIDENCE
The following documentation can be presented as proof of residence:

Current Rental Receipt or Notarized Letter from Landlord Stating Residence
Current Household Bill, Telephone, Gas, Cable or Electrical
Current Mail Addressed to Adult Family Member – Post Office marked
Current Letter of Proof of Residence

INCOME
The following documentation can be presented as proof of income:

Four (4) Weeks of Income or Letter from Employer Stating Gross Income
Income Tax Returns for most Current Year
If Unemployed, Current Letter of Support or Unemployment book/check or stub

ADDITIONAL

Letter to Wyckoff Heights Medical Center requesting help to pay the hospital bill.

Please bring original documents to this office between the hours of 9:00AM – 4:00PM only.

Thank you,

_____
Customer Service Representative

WYCKOFF HEIGHTS MEDICAL CENTER Financial Assistance Summary

Wyckoff Heights Medical Center recognizes that there are times when patients in need of care will have difficulty paying for the services provided. Wyckoff Heights Medical Center's charity care/financial assistance program provides discounts to qualifying individuals based on your income. In addition, we can help you apply for free or low cost insurance if you qualify. Just contact our Financial Counselor at (718) 963-7356 for free, confidential assistance.

Who qualifies for a discount?

Charity care/financial assistance is available for patients with limited incomes and no health insurance.

Everyone in New York State who needs emergency services can receive care and get a discount if they meet the income limits.

Everyone who lives in the five boroughs of New York City can get a discount on non-Emergency medically necessary services at Wyckoff Heights Medical Center if they meet the income limits. You cannot be denied medically necessary care because you need financial assistance.

What are the income limits?

The amount of the discount varies based on your income and the size of your family. If you have no health insurance these are the income limits:

Family Size	Annual Family Income	Monthly Family Income	Weekly Family Income
1	$ 15,060.00	$ 1,255.00	$ 313.75
2	$ 20,440.00	$ 1,703.33	$ 425.83
3	$ 25,820.00	$ 2,151.67	$ 537.92
4	$ 31,200.00	$ 2,600.00	$ 650.00
5	$ 36,580.00	$ 3,048.33	$ 762.08
6	$ 41,960.00	$ 3,496.67	$ 874.17

- Based on the 2024 Federal Poverty Guidelines

What if I do not meet the income limits?

If you cannot pay your bill Wyckoff Heights Medical Center offers a payment plan to those patients who meet the income limits. The amount you pay depends on the amount of your income.

Can someone explain the discount? Can someone help me apply?

Yes free confidential help is available. Call our Financial Counseling Department at (718) 963-7356.

If you do not speak English, someone will help you in your own language.

The Financial Counselor can refer you to someone who can tell you if you qualify for free or low-cost insurance, such as Medicaid, Child Health Plus, and Family Health Plus.

If you do not qualify for low-cost insurance the Financial Counselor will help you apply for a discount. The Counselor will help you fill out the forms and tell you what documents you need to supply.

What do I need to apply for a discount?

You will need to provide proof of income for the past 3 months (for example: pay stub, Income Tax return) and proof of identity. **If** you cannot provide any of these you may still be able to apply for financial assistance.

What services are covered?

All medically necessary services provided by Wyckoff Heights Medical Center are covered by the discount. This includes outpatient services, emergency care, and inpatient admissions.

Cosmetic services and charges from *private doctors* who provide services in the hospital are <u>not</u> covered. You should talk to private doctors to see if they offer a discount or payment plan.

How much do I have to pay?

The amount for an outpatient service or the emergency room starts from $0 for children and pregnant women, depending on your income. The amount for outpatient service or the emergency room starts from $15 for adults, depending on your income.

Our Financial Counselor will give you the details about your specific discount(s) once your application is processed.

How do I get the discount?

You have to fill out the application form. As soon as we have proof of your income, we can process your application for a discount according to your income level.

You can apply for a discount before you have an appointment, when you come to the hospital to get care, or when the bill comes in the mail.
Send the completed form to the Admitting Department at Wyckoff Heights Medical Center, 374 Stockholm Street, Brooklyn, New York 11237. You have up to 90 days after receiving services to submit the application.

Prompt Pay Discounts is as follows:
Self-pay patients may receive a 10% discount on outstanding self-pay balances, co-insurance or deductible amounts if the reduced balance is paid in full. Patients with charity care or co-payments do not qualify.

How will I know if I qualified for the program?

Wyckoff Heights Medical Center will send you a letter within 30 days after completion and submission of documentation, advising you if you have been approved and the level of discount received.

What if I receive a bill while waiting for the approval?

You cannot be required to pay a hospital bill while your application for a discount is being considered. If your application is turned down, the hospital must tell you why in writing and must provide you with a way to appeal this decision to a higher level within the hospital.

What if I have a problem I cannot resolve with the hospital?

You may call the New York State Department of Health complaint hotline at 1-800-804-5447.