WYCKOFF HEIGHTS MEDICAL CENTER ADMINISTRATIVE
POLICY AND PROCEDURE MANUAL CODE: 5.2

CATEGORY:	Revenue Cycle/Finance
SUBJECT:	Charity Care/Financial Assistance
ORIGINATOR:	October 20, 2024
EFFECTIVE DATE:	Vali Gache, CFO

CODE: 5.2

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 processNote: 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.

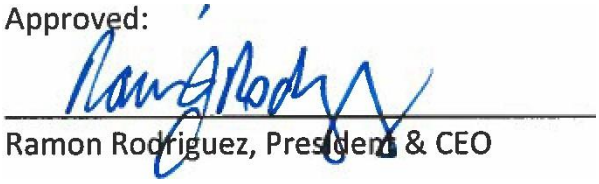
8. If applicable, Vice President of Finance reviews the Charity Care request
   Sign and date the form, and return it to the Director who referred the worksheet. Proceed to step #9a.

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



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 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	

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 Wyckoff Height Medical Center's financial assistance office at 718-963-7317.
- If you need additional assistance with this application or help appealing a decision, you can reach out to Community Health Advocates: 718-963-7186.

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.

Individuals up to 400% of the federal poverty level are eligible for financial assistance. **Federal Poverty Levels (2024)**			
Household Size	**200%**	**300%**	**400%**
1 Person	$30,120	$45,180	$60,240
2 Persons	$40,880	$61,320	$81,760
3 Persons	$51,640	$77,460	$103,280
4 Persons	$62,400	$93,600	$124,800
5 Persons	$73,160	$109,740	$146,320
6 Persons	$83,920	$125,880	$167,840
7 Persons	$94,680	$142,020	$189,360

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%.

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.

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.