Financial Assistance Policy – Plain Language Summary

Mather Hospital recognizes that many of the patients it serves may be unable to access quality health care services without financial assistance. Mather Hospital has developed a program which helps to ensure that we uphold our mission of providing quality healthcare to the community while taking into consideration the patient's ability to pay as determined by our reasonable and unbiased policy.

Procedure

A. Purpose

The purpose of our Financial Assistance is to provide services, sometimes free of charge, or at a reduced rate, for all or part of a patient's care.

For the purpose of determining which services may be offered financial assistance, services will be defined by all of Nassau and Suffolk County's primary service areas for emergency services. Financial assistance will be utilized in those cases where the Senior Director of Patient Financial Services, or other authorized personnel, determines that the patient, due to financial position, or limited assets, is unable to pay for all or part of their care including deductibles, co-payments, coinsurance and/or services not covered by insurance or other third-party payers.

The Director of Patient Financial Services, or authorized personnel, makes a final decision on financial assistance (on a case-by-case basis). In the event that a patient's bill is ineligible for Financial Assistance, either in part or in its entirety, the hospital can provide interest free payment plans that correlate with the patient's income and assets, but will not exceed ten percent of the patient's gross monthly earnings. If a patient is cooperating with an agreed upon extended payment plan to settle an outstanding bill with the facility, the hospital will not send the unpaid bill to a collection agency/attorney.

B. Publication/Public Access

It is the hospital's policy to have the Financial Assistance Application in other languages wherein the primary language of the residents of the community served by Mather Hospital represents the lesser of 5 percent or 1,000 individuals within the population likely to be affected or have an encounter with Mather Hospital. Translated versions are available upon request by calling 631-473-1320 extension 4037.

Postcards with the Financial Assistance Representatives' contact information are provided to patients who express a need for financial assistance. Each admission packet contains an insert informing patients about the Financial Assistance Program.

All of the patient statement mailers include a Financial Assistance statement informing patients of the Financial Assistance program and contact information. The hospital's website also has a dedicated section which includes frequently asked questions and the Financial Assistance Program summary.

C. Application Process

In accordance with the Affordable HealthCare 501R regulations, all self-pay patients are no longer billed for total charges. At the time of the bill, the account is reduced to the AGB (Amounts Generally Billed) rate of 26.31% of charges which includes NYS surcharge for hospital services and 24% for professional services. (For further details of the AGB and how it is calculated, please see the Amounts Generally Billed Policy and Procedure). The Patient is then offered to either pay in full or enter into an appropriate payment arrangement. If the patient believes they are still unable to afford the bill, they may then complete a Financial Assistance Application. Under the Financial Assistance guidelines, any discount the patient is eligible for is applied to the balance after the AGB reduction.

D. Application Criteria

A Financial Assistance Application is provided to all patients who inquire about the program. Each application includes a checklist of all required documentation and a self-addressed return envelope.

Once the application and all required documentation have been returned, Mather Hospital utilizes guidelines for the current Federal Poverty Level to determine eligibility under the Financial Assistance Program. If financial assistance, in part or whole, is determined to be applicable, the designated Financial Assistance Representative uses the Financial Assistance Allowance code to make all necessary adjustments.

E. Determining Applicable Discounts

The discount a patient receives is based upon the family income, the size of the family, and how it aligns with the Federal Poverty Guidelines. Patients who fall below 150% of the Federal Poverty guidelines are eligible for a 100% discount, with the exception of a nominal fee when applicable. Patients who fall 451% and above the federal poverty guidelines are responsible for the Amounts Generally Billed. For a full breakdown of all discounts, please see Table A below.

**All Patients eligible for a 100% discount are subject to a nominal fee as defined by New York State.*

Table A

Family Size	Family Income	*Eligible for 100% Financial Assistance (Up to 150%)	*Eligible for 75% Financial Assistance (Up to 250%)	*Eligible for 50% Financial Assistance (Up to 350%)	*Eligible for 25% Financial Assistance (Up to 450%)
1	$12,880.00	$19,320.00	$32,200.00	$45,080.00	$57,960.00
2	$17,420.00	$26,130.00	$43,550.00	$60,970.00	$78,390.00
3	$21,960.00	$32,940.00	$54,900.00	$76,860.00	$98,820.00
4	$26,500.00	$39,750.00	$66,250.00	$92,750.00	$119,250.00
5	$31,040.00	$46,560.00	$77,600.00	$108,640.00	$139,680.00
6	$35,580.00	$53,370.00	$88,950.00	$124,530.00	$160,110.00
7	$40,120.00	$60,180.00	$100,300.00	$140,420.00	$180,540.00
8	$44,660.00	$66,990.00	$111,650.00	$156,310.00	$200,970.00

Source: Calculated using data from the Federal Register, January 2021 for families/households with more than 8 persons, add $4,540 for each additional person. U.S. Department of Health and Human Services (HHS)

- 150% & Below: Patient's bill is discounted 100%
- 151-250%: Patient's bill is discounted 75%
- 251-350%: Patient's bill is discounted 50%
- 351-450%: Patient's bill is discounted 25%
- 451% & Above: Patient is responsible for amounts generally billed in accordance with the Affordable Healthcare 501R Regulations.

F. Nominal Payment Guidelines

In accordance with New York State regulations, a nominal fee is charged to patients who are eligible for 100% financial assistance. They are as follows:

- Interventional Radiology - $150
- Emergency Room - $50
- Infusion - $15 with a cap of $150 per month.
- MRI's, Mammogram, sonogram, Cat Scan, Bone Scans, Nuclear Medicine test, other radiology services - $150
- X-Ray - $15
- Inpatient - $150
- Neurology Services - $150
- Physical Therapy, Occupational Therapy, Speech Therapy - $15 with a cap of $150 per month.
- Pre-surgical Testing - $15
- Hyperbarics - $150 per visit

- Ambulatory Surgery – $150/Procedure
- Clinic Services – $15/Visit with a cap of $150 per month.
- Prenatal and Pediatric ER/Clinic Services – No Charge

G. Time Requirements for Determination

Once an application has been received and a comprehensive review has been conducted, one of the following letters is forwarded to the patient, via mail, explaining the result of the application. This letter is mailed within 30 days of the hospital receiving the Financial Assistance Application. The letters are as follows:

- Letter #1: Confirms the patient is eligible for financial assistance
- Letter #2: Confirms the patient is eligible for partial financial assistance
- Letter #3: Informs the patient they are ineligible for financial assistance at this time
- Letter #4: Informs the patient that additional information is required in order to determine financial assistance eligibility
- Letter#5: Final reminder letter to the patient to apply for financial assistance

Please note that patients are permitted a minimum of 240 days from the date noted on the first post-discharge bill to apply for Financial Assistance. Per the IRS, a billing statement is considered "post-discharge" whether inpatient or outpatient. The patient must still provide all required documentation proving they are indigent. If a patient applies for financial assistance in regard to an open balance from a previous year, or to have the previous year's account considered, the patient must provide their tax return for the year prior to account in question.

All discounts received through the Financial Assistance Program are effective for one year; therefore, if a patient continues to require financial assistance, they must re-apply on an annual basis.

H. Billing/Collections

A patient is allowed to apply for financial assistance at any point from admission to final payment of the bill. The facility does recognize that a patient's ability to pay over an extended period may be substantially altered due to illness or financial hardship, resulting in a need for financial services.

The collection agencies and collection attorneys we utilize are advised to adhere to the same high standards incorporated in Mather Hospital's Financial Assistance Policy. Our collection agencies and attorneys do not begin their collection process on an open account if a patient has submitted a completed Financial Assistance Application and is in the process of being reviewed to determine eligibility.

Legal action, including the garnishing of wages, may be pursued by Mather Hospital only when there is sufficient evidence that the patient or responsible party has the income and/or assets to meet his/her obligation. The facility does not force the sale or foreclosure of a patient's primary residence to pay an outstanding medical bill. Liens are permitted only when there is evidence that the patient or responsible party has sufficient income and or assets to meet his/her obligation.

I. Presumptive Eligibility

Financial Assistance determination may not require extensive documentation based on account balance criteria. Account balances below a certain dollar amount may not require extensive documentation to administer a Financial Assistance allowance.

The facility considers significant assets owned by a patient and or a legally responsible individual for all cases including patients at or below 150% of the Federal Poverty Level. A decision may be made by the Director of Patient Financial Services to grant financial assistance based on the following: account balances, information received via phone calls, face to face interviews, admitting information and/or medical record information. An example of these types of cases might include homeless patients, foreign patients, drug rehabilitation, non-retroactive Medicaid coverage, Medicaid co-payments, etc.

The facility also runs an estate search on all deceased patients with an open balance. If the estate search deems the patient is without an estate, all open balances are written-off using the presumptive eligibility allowance.

J. Recordkeeping/Reporting

The Financial Assistance department maintains a detailed log of all Financial Assistance applicants and recipients in accordance with the necessary criteria required for annual reporting to various governmental agencies.

On a monthly basis, the Systems Analyst sends Transunion the Bad Debt qualified accounts. When returned from Transunion, the accounts are divided into four tiers which include the following: Presumptive Eligibility, Low Collectability, Medium Collectability, and High Collectability:

- Presumptive Eligibility: Accounts are automatically written off using the Presumptive Eligibility allowance.
- Low Collectability/Medium Collectability: Accounts continue through the collections process and are assigned to an agency. If the patient contacts the agency inquiring about Financial Assistance, these cases require the Director's approval. A full and completed Financial Assistance application must be returned promptly within 30 days in order to be considered for financial assistance.
- High Collectability: These accounts are reviewed by our credit and collection unit and held from collections for 30 days. If after 30 days the patient has not created a payment arrangement or paid in full, the account is sent for further collection efforts.

K. Approval Authorizations Levels

Effective January 1, 2021 the facility has assigned specific members of the management team to oversee write-off approvals by specific dollar amount ranges. Below are the individuals assigned to the approval tiers:

- $25,000 and Under – Assistant Director of Patient Financial Services
- $25,001 and Over - Director of Patient Financial Services

L. Appeal Process

In the event a Financial Assistance applicant is denied or does not agree with the determination, the patient may appeal the decision within 30 days of the denial notice by contacting the Financial Assistance Representative at extension 4037 for a Financial Assistance Appeal Form.

Each year Mather Hospital includes a dollar amount in the Annual Operating Budget which is approved by the Board of Directors for the purpose of providing financial assistance.

M. Mather Hospital Financial Assistance Office

A financial assistance representative can be reached by phone at 631-473-1320 extension 4037, Monday through Friday from 8am – 4pm.

Mailing address:
Mather Hospital
Financial Assistance Department
100 Highlands Blvd Box 9
Port Jefferson, NY 11777
631-473-1320 extension 4037
Web address: https://www.matherhospital.org/patients-visitors/for-patients/paying-for-your-hospital-care/financial-assistance/

Mather Hospital Financial Assistance Application Form

In order to determine whether or not you are eligible for financial assistance, we request this application be completed as thoroughly as possible. Please be advised that you are required to supply proof to support the statements made in this application including your identity, residence, income, and resources.

Patient's Name:_____Person responsible for the bill: _____

Address: _____Phone #: (_____)_____- _____

Employer:_____Address: _____

Phone #: (_____)_____-_____Position:_____Salary: _____

Union or Local Affiliation:_____Number of Dependents in Household: _____

Do you have any hospitalization insurance? Yes_____No _____

If yes, Medicare:_____Medicaid:_____Blue Cross:_____Other (specify): _____

Insurance Policy or Certificate #:_____

Name of Bank:_____Address: _____

Savings Account #:_____Checking #:_____

Have you applied for Medicaid medical assistance? Yes_____No _____

If yes, when:_____Results: _____

I understand that by signing this document I am applying for Financial Assistance at Mather Hospital. I certify that the above information is true and accurate to the best of my knowledge. I also understand that Mather Hospital may verify the information I am providing and that deliberate falsifications may disqualify my application from being considered for financial assistance. I will cooperate with this verification and provide all needed evidence to support the information I have declared on this application.

Effective 2/1/1998, a TransUnion credit report may be required on specific Financial Assistance requests.

_____ _____

Signature of patient or responsible party *Date*

All English documents are available in Spanish and can be furnished upon request at (631)473-1320 X4037