

## Richmond University Medical Center

<b>Department:</b> Finance/Patient Access/Business Office	<b>Policy Description:</b> Richmond University Medical Center (RUMC) - Financial Assistance Policy (FAP)
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<b>Approved:</b>	<b>Retired:</b>
<b>Effective Date:</b> January 2007 <b>Revised:</b> October 2024	<b>Reference Number:</b>

**POLICY:** To provide medically necessary medical care to those individuals in need, regardless of their ability to pay who reside in New York and to make certain that all requests for Financial Assistance are evaluated and processed fairly and consistently with dignity, compassion and in a respectful manner, consistent with RUMC mission and values.

Under no circumstances will non-elective medically necessary services be delayed pending eligibility for Financial Assistance or any other insurance coverage. All patients receiving medically necessary services that are including inpatient, outpatient, ambulatory surgery, emergency services, etc., are potentially eligible for financial assistance based upon the receipt of proof of identification and income. Cosmetic services are excluded from this policy and procedure and are considered ineligible services for the Financial Assistance Program.

This Financial Assistance Policy ("FAP" or the "Policy") sets forth the process that will be used to determine whether RUMC patients, whether uninsured or underinsured, are eligible for Financial Assistance or a clinic sliding fee scale discount. Based on patient's family size, patients with an income of up to 400% of the Federal Poverty Guideline will be eligible for a discount on their hospital bill.

**PURPOSE:** To establish guidelines for processing Financial Assistance Applications in a fair, timely and effective manner. The Policy is intended to comply with the Financial Assistance Policy requirements of Internal Revenue Code Section 501 (r) and Section 2807-k(9-a) of the New York Public Health Law.

**NOTIFICATION:**

The RUMC Financial Assistance Summary is available to the public, in English and several other foreign languages, as determined by RUMC's annual language needs assessment, in the Emergency Department and all other intake and registration areas of each hospital within the System. Notification of RUMC's Financial Assistance Program and information on how to obtain further information is also printed on all bills and statements sent to patients.

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### SPECIAL FINANCIAL GUIDELINES:

1. Financial Assistance is defined as health care services that are provided at a reduced fee to patients who are uninsured or underinsured and do not have nor can obtain adequate financial resources or other means to pay for their medically necessary medical care.
2. Partial Financial Assistance will solely be based on the patient's family size and income, and shall not take into account age, gender, race, color, national origin, religion, social, immigrant status, sexual orientation, gender identity, spousal affiliation, physical handicap, or mental handicap.
3. A sliding fee scale and situational consideration will be available to families with resources at or below 100% of the minimum Federal Poverty Level. Extraordinary situations will be reviewed and approved or denied on a per case basis by the Assistant Vice President of Revenue Cycle and/or the Chief Financial Officer.
4. There are six (6) defined patient categories for reduced charges that are based on income and family size. Patients/guarantors that do not qualify for an FAP reduction will be responsible for paying the hospital's self-pay fee schedule. The self-pay fee schedule is based on reimbursement from Medicare, Medicaid, or the highest volume commercial payer or the highest volume utilization in the prior year.
5. Patients that are required to pay a percentage of the self-pay fee schedule will be asked to pay the amount in full or make a payment arrangement for a reasonable monthly amount. Please see the policy and procedure on Billing and Collections Policy for Self Pay & Payment Plan Accounts.
6. The flat fee clinic visit rate includes the visit, physician charge and tests provided in the clinic setting on the same day as the physician visit. All hospital services are excluded from the flat daily clinic rate and include, but are not limited to, MRI's, CTs, interventional radiology, ambulatory surgery, etc., which are due and payable at the patient's approved Financial Assistance Program rate. See attached Financial Assistance Reduced Fee Schedules – Exhibits #1 Income Guidelines including Clinic Flat Fees Schedule
7. This Financial Assistance policy also applies to medically necessary non-covered services and non-covered charges for days exceeding a length-of-stay limit for patients either eligible for or covered by Medicaid who otherwise meet the Hospital's policy criteria.

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### 8. HOSPITAL BASED CHARGES

- Group #1 100% write-off - No bill sent to the patient
- Group #2 100% write-off - No bill sent to the patient
- Group #3 95% write-off - Patient pays 5%
- Group #4 90% write-off - Patient pays 10%
- Group #5 85% write-off - Patient pays 15%
- Group #6 80% write-off - Patient pays 20%

9. Once a patient has submitted a completed application, including all required supporting documentation, RUMC will review the application and make a determination for financial assistance. A letter of approval or denial will be sent to the patient within a maximum of thirty (30) days after receipt of the patient's completed application. The patient may disregard any bill that may be sent until the hospital has rendered a decision on the application and the patient receives an approval or denial letter.
10. Patients may apply/re-apply for financial assistance at any time when their personal financial situation changes.

#### **ELIGIBILITY:**

1. Patient Access and the Business Office personnel will be available to help patients identify financial options and/or assistance programs.
2. Patients are required to be a resident of New York State to be eligible for this program.
3. Financial Assistance is always secondary to all other financial resources available to the patient, including insurance, government programs, third party liability and other indicators of party's ability to pay.

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4. Patients are required to allow RUMC to bill their insurance carrier to be eligible for the Financial Assistance Program.
5. Patients who are found to be potentially eligible for New York State Medicaid after a financial screening are required to complete a Medicaid application in order to be considered for RUMC's Financial Assistance Program.
6. Patients who are unable to submit required information will be interviewed to document their situations, such as the homeless, critically ill, etc. These facts will be taken into consideration when determining eligibility.
7. Patients applying for Medicaid either through the State or through a vendor that are subsequently denied may be eligible for Financial Assistance at RUMC. The patient will be required to sign a Financial Assistance Application to be eligible. The Financial Counselor or Customer Service will review the Medicaid application and, if adequate information is available, the Financial Counselor or Customer Service may submit the information for approval based on the patient's financial situation.
8. Any collection agency or accounts receivable vendor under contract with the System will be required to follow RUMC's Financial Assistance policies and to provide patients with information on how to apply for the program, if appropriate.

### ELIGIBILITY DETERMINATION:

1. Patients may be eligible for Financial Assistance prior to receiving services as well as retroactively.
2. RUMC Patient Access and the Business Office along with third party professional collection agencies or other agents of RUMC will administer this Financial Assistance policy.
3. The patient or the patient's advocate may request financial Assistance.
4. Anyone making a request for Financial Assistance may obtain an application from the RUMC website, which includes instructions on how to apply.
5. Consideration for financial assistance will occur once the applicant completes, signs and submits the application with the appropriate documents. Applicant may be required to apply for Medicaid after submission of a financial assistance application except in the case where a Medicaid application was previously completed and denied.

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6. Consideration for Financial Assistance Program includes a review of the responsible party’s annual household income, number of people in the home, existing debt and other indicators of party’s ability to pay. These are guidelines, and each individual situation will be reviewed independently and shall not take into account age, gender, race, color, national origin, religion, social or immigrant status, sexual orientation, gender identity, spousal affiliation, physical handicap, or mental handicap. The Vice President of Revenue Cycle may grant approval if there are extenuating circumstances.
7. RUMC will keep all applications and supporting documentation confidential.
8. Incomplete applications will be returned to the guarantor with a statement of what information is needed and with a specific time frame for submitting the missing information. Patients are requested to provide information within thirty (30) days to submit a completed application that includes all required documentation needed by the hospital to make a decision.
9. Financial Assistance will not be considered without a complete Financial Assistance application unless sufficient information can be obtained that allows for a final determination. In extenuating circumstances, where a financial hardship can be documented, RUMC may offer financial assistance based upon its own determination.
10. Patients must re-qualify for Financial Assistance annually. Eligibility can be re-evaluated at any time by the hospital based on changes to the patient’s financial situation.

**PROVIDER GROUPS EXCLUDED**

The following provider groups are excluded from FAP: Anesthesia and Radiology vendors.

**APPEALS:**

1. The responsible party may appeal a denial by providing additional information, such as income verification or an explanation of extenuating circumstances, to Director of Patient Access within thirty (30) days of receiving notification. The business office will review all appeals. The responsible party or guarantor will be notified of the appeals outcome.
2. Collection follow-up on accounts will be suspended during the appeals process.

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**PROCEDURE:**

**RESPONSIBLE PARTY** Financial Counselor (FC)

**ACTION**

1. The Financial Counselor will document all activity on the patient’s account. Then obtain a request for financial assistance from the patient.  
  
The Financial Counselor will review the patient’s information for possible third party coverage and/or other self-pay options, such as credit cards and payment plans. After all third party and personal resources have been exhausted, proceed to step #3.
2. If the patient is found to be potentially eligible for Medicaid, inform the patient that they need to complete and submit a New York State Medicaid application within two (2) weeks prior to being reviewed for Financial Assistance:
  - a. Give or send the patient/guarantor a Medicaid application to complete and inform the party that a Financial Counselor is available to assist them. (Refer to the Medicaid Application procedure); or
  - b. Refer the patient/guarantor to an on-site Medicaid Application Specialist or direct the party to a Medicaid location where they can apply.
3. Advise the patient/guarantor to notify the Hospital immediately when they receive notification from Medicaid:
  - a. If the patient receives Medicaid approval, the Financial Counselor will input the Medicaid billing data, change the insurance plan to Medicaid, and refer the account to billing and document activity in the system. Then, the account will be billed to Medicaid.
  - b. If the patient is denied, the patient must bring in or mail a copy of the Medicaid denial or a denial form from an on-site representative/deputized Medicaid Representative. A Financial Assistance application (Exhibit #2) with a RUMC Financial Assistance cover letter (Exhibit #3) will be given or mailed to the party to begin the process.
  - c. If the patient has completed a Medicaid Application through the Medicaid Application Specialist and the application is denied, the patient may be evaluated and approved for Financial Assistance by the hospital and no additional documents will be required from the patient. The Financial Counselor will obtain copies of the Medicaid Application from

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the Medicaid Application Specialist and obtain family size, income levels and family expense information from the application. Using this information, the Financial Counselor will determine the patient's eligibility for the FAP program. If the application is incomplete, it will be denied and a denial letter will be forwarded to the patient and the reason for denial will be documented in Meditech.

4. If the patient receives notification of a Medicaid denial, give or send the patient/guarantor a Financial Assistance application with a Financial Assistance cover letter, which explains the requirements. Inform the patient (in person or via phone) of the following:
  - a. The Financial Assistance application must be completed and returned with all completed documentation within twenty (20) days.
  - b. **Failure to provide the information listed below may cause the patient's Financial Assistance Application to be denied.**
  - c. The Financial Counselor is available to assist in filling out the form if needed, and the Hospital can make copies of the required data if they are unable to do so.
  - d. **Please do not** mail original documents.
  
5. Eligibility requirements will be based upon a combination of the following criteria:
  - a. Family income
  - b. Number of dependents in family (Family members are defined as persons occupying the same household and who are identified as dependents for tax purposes).
  - c. Estimated living cost
  - d. Estimated medical bills
  - e. Other hardships
  - f. Proof of New York State Residency (i.e. driver's license, utility bill, lease agreement)

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1. Proof of identification is required and will be verified. NOTE: In extraordinary situations, such as homeless patients the required data may not be available. In such cases, the Financial Counselor must document all conversations with a clear description of the patient's situation. Items listed below need to be copied and attached to the Financial Assistance application:
  2. Government issued identification (one form of identification is required):
    - a. Driver's License
    - b. State Identification Card
    - c. Passport
    - d. Military Identification Card
    - e. Registration Card (Permanent Resident - when applicable)
    - f. Marriage Certificate (when applicable)
    - g. Birth, Baptismal or Citizenship Certification (when applicable)
    - h. Mail addressed to patient/guarantor
  
6. Proof of income is required and will be verified. Items listed below need to be copied and attached to the Financial Assistance Application.
  1. If unemployed, a notarized letter from the patient/guarantor documenting all facts supporting the need for assistance and a letter from the person that is supplying basic needs.
  2. If employed, for wages and salaries one or more of those items listed below should be included for proof of income.
    - a. Paycheck stubs from the most current period.
    - b. Receipts from self-employment or from a business after business expenses.
    - c. Regular pay stubs showing payments from:



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1. Public assistance
  2. Social Security Administration
  3. Unemployment/Workers' Compensation
  4. Strike benefits from union funds
  5. Veterans' benefits
  6. Alimony
  7. Child support
  8. Military family allotments or other regular payments from an absent family member or someone not living in the household
  9. Government employee pension, private pension and regular insurance or annuity payments
7. Copies of current bank account statements for all checking and savings accounts.
8. Note the following information on the Financial Assistance Log for the appropriate month:
1. Date application was given to patient/guarantor
  2. Patient name
  3. Account number(s)
  4. Balance due
9. The Financial Counselor must document all activity in the system, receive the patient's completed Financial Assistance application and complete the following:
1. Create a patient folder to store all documents
  2. Enter the date the application was received on the Financial Assistance System

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3. Document activity in the hospital system

<b>Authorization Levels</b>	<b>Approval Range</b>
Manager	\$00.00-\$500.00
Director of Pt Access/Manager	\$501.00 - \$10,000.00
Asst.Vice President of Revenue Cycle	\$10,001.00 - \$50,000
VP / CFO	\$50,001.00 and above

4. Review the application for completeness (verify that all fields are completed with complete and original signatures, copies of required data are attached, family income is within the RUMC guidelines and all special circumstances are clearly stated). Discuss any discrepancies in the data with your immediate Supervisor.

- a. If complete, proceed to step #15.
- b. If incomplete, proceed to step #18b.

10. Complete the top section of the Financial Information Worksheet (Exhibit #4).

- 1. Review and evaluate the information to make a Financial Assistance recommendation
  - a. Determine gross yearly income amount.
  - b. Determine size of family and poverty guideline amount from the RUMC Financial Assistance Reduced Fee Schedule / Federal Poverty Guidelines (Exhibit #1) based on the sliding scale (refer to Billing and Collections Policy for Self Pay & Payment Plan Accounts Policy) establish the appropriate assistance percentage, if any that will be given.
  - c. Make a recommendation for approval or denial and write a brief summary on the worksheet.

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11. The Financial Counselor or Registrar will forward the completed application with all supporting documents to the appropriate manager for approval of the amount to be adjusted. All information must be documented in the Meditech comments on the account.
12. The Manager will review and make a final determination after reviewing the documents:
  1. If denied, the Supervisor will document reason, sign the form and return to the Financial Counselor. Proceed to step #18.
  2. If approved, the Supervisor will sign and date the Financial Information Worksheet and return it with all the financial documentation to the Financial Counselor. Then, proceed to step #20.
13. The Financial Counselor will receive denial and complete the following steps:
  1. If patient does not qualify for Financial Assistance, go to step # 19.
  2. If the patient does not quality because additional information is required,
    - a. Send the patient a 'Request for Additional Information' letter (Exhibit #5).
    - b. Document activity in the system and on the Financial Assistance Log
    - c. Place the application in the 'Pended' file
  3. Review 'Pended' files weekly, if information has not been received:
    1. Make two (2) attempts to contact the patient/guarantor
    2. If unsuccessful, determine the case to be a denial and proceed to next step.
14. Send the patient a 'Denial Notice' (Exhibit #6). Alternatively, if this is a clinic visit, inform the patient.
  1. Document activity in the system and on the Financial Assistance System.
  2. Place the original documents in the Financial Assistance Completed File (alphabetized). Process is complete unless the patient appeals.

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15. Once approval is received, the Financial Counselor should complete the following steps:
  1. If the patient received a discount of 100%:
    - a. Send the patient/guarantor an Approval Notice (Exhibit #7) – clinic patients may be notified in person.
    - b. Request an adjustment for the full amount
    - c. Document activity in the system and on the Financial Assistance System.
    - d. Place the original documents in the Financial Assistance Completed File (alphabetized) "Process Completed"
  2. If partial discount has been approved and the patient is responsible for a percentage of the balance:
    - a. Inform the party of the discounted amount in person or via phone call.
    - b. Arrange to have the balance paid in full or set up payment arrangements.
    - c. Send the patient an Approval Notice and Payment Agreement.
    - d. Place the file in the 'Approved' file pending payment.
    - e. Document activity in the system.
  
16. The Financial Counselor will receive payment and a payment agreement when required from patient/guarantor:
  1. The Financial Counselor should pull pended file.
  2. Set up payment arrangement in system if needed.
  3. Request adjustment for Financial Assistance.
  4. Document activity in the system and on the Financial Assistance Log.
  5. Place the original documents in the Financial Assistance completed file (alphabetized until the application process is complete.+)

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17. The Financial Counselor should weekly review each application in the pended file:
  1. If payment in full has been received proceed to step #21
  2. If payment is not received within three (3) weeks, make two (2) attempts to contact the patient. If no response, return to step #19.
  
18. At the end of each month:
  1. E-mail your Request for Financial Assistance Log to your Supervisor/Manager/Director, which will include the monthly summary section.
  2. The vendor will compile all statistics from the system into one (1) report and distribute to the RUMC management team.

### **COMPLIANCE:**

The System's Corporate Compliance Officer will annually review the policy and do periodic audits to certify compliance with these requirements.

### **EXHIBITS**

1. Financial Assistance Reduced Fee Schedule
2. Financial Assistance Application
3. Financial Assistance Cover Letter
4. Financial Assistance Worksheet
5. Request for Additional Information Letter
6. Denial Notice
7. Approval Notice

# RICHMOND UNIVERSITY MEDICAL CENTER

## FINANCIAL ASSISTANCE REDUCED FEE SCHEDULE – **Exhibit 1**

Richmond University Medical Center will provide Financial Assistance to all qualifying patients for non-elective services. Eligibility will be based solely on ability to pay and will not be based on age, sex, race, creed, religion, disability, sexual orientation, national origin, handicap, marital or veteran status. Full Financial Assistance will be limited to persons whose family income is not more than 100% of the current Federal poverty guidelines established by the Department of Health. A sliding fee scale (for Hospital based services excluding clinics) and flat fees for Clinic visits will be granted to families with resources up to 400% of the poverty level. Special consideration will be given to patients with extenuating circumstances. Requests for Financial Assistance may be made in Patient Access, Financial Counseling, Social Service, Counselor, Clinics and/or Business Office.

There are six (6) income categories eligible for a reduction of charges, which are based on income and family size. Patients/guarantors will be responsible for paying a percentage of the hospital’s reduced self-pay fee schedule or flat fee rates for clinic visits.

### FINANCIAL ASSISTANCE INCOME GUIDELINES

#### **POVERTY GUIDELINE**

<b>SIZE OF FAMILY</b>	<b>GROUP #1</b>	<b>GROUP #2</b>	<b>GROUP #3</b>	<b>GROUP #4</b>	<b>GROUP #5</b>	<b>GROUP #6</b>
<b>% FPL</b>	<b>100%</b>	<b>101% -200%</b>	<b>201%-250%</b>	<b>251%-300%</b>	<b>301-350%</b>	<b>350%-400%</b>
1	\$15,060	\$15,061-\$30,120	\$30,121-\$37,650	\$37,651-\$45,179	\$45,181-\$52,709	\$52,711-\$60,240
2	\$20,440	\$20,441-\$40,880	\$40,881-\$51,100	\$51,101-\$61,319	\$61,321-\$71,539	\$71,541-\$81,760
3	\$25,820	\$25,821-\$51,640	\$51,641-\$64,550	\$64,551-\$77,459	\$77,461-\$90,369	\$90,371-\$103,280
4	\$31,200	\$31,201-\$62,400	\$62,401-\$78,000	\$78,001-\$93,599	\$93,601-\$109,199	\$109,201-\$124,800
5	\$36,580	\$36,581-\$73,160	\$73,161-\$91,450	\$91,451-\$109,739	\$109,741-\$128,029	\$128,031-\$146,320
6	\$41,960	\$41,961-\$83,920	\$83,921-\$104,900	\$104,901-\$125,879	\$125,881-\$146,859	\$146,861-\$167,840
7	\$47,340	\$47,341-\$94,680	\$94,681-\$118,350	\$118,351-\$142,019	\$142,021-\$165,689	\$165,691-\$189,360
8	\$52,720	\$52,721-\$105,440	\$105,441-\$131,800	\$131,801-\$158,159	\$158,161-\$184,519	\$184,521-\$210,880

For family units with more than eight family members add \$5,380 for each additional member. **(Federal Poverty Guidelines 2024)**. Eligibility will be conditional on a person applying for local, state, federal or other third party assistance or insurance.

#### HOSPITAL BASED CHARGES

*Includes Inpatient, Outpatient, Emergency*

*Department, Outpatient Surgery, etc.*

#### CLINIC FLAT FEES

*Includes all services provided by the*

*Clinics - includes basic tests*

Group #1	100% write/off - No bill to patient	Patient pays - \$ 0
Group #2	100% write/off – No bill to patient	Patient pays - \$ 0
Group #3	95% write/off - Patient pays 5%	Patient pays - \$ 7.60
Group #4	90% write/off - Patient pays 10%	Patient pays - \$15.20
Group #5	85% write/off - Patient pays 15%	Patient pays - \$22.80
Group #6	80% write/off - Patient pays 20%	Patient pays - \$30.40

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**Patients that exceed the Financial Assistance Guidelines** above may choose the self-pay clinic option and pay \$152.00 for all routine services provided at the clinic on the same day with laboratory services provided within six days of the initial clinic visit are included in the flat clinic rate. “Routine services” are defined as those services provided on the same day in the clinic and excludes any services provided at the hospital, including but not limited to, MRIs, CTs, outpatient surgeries, upper and lower gastrointestinal procedures, all interventional radiology services, etc.

Subject to the availability of certain other resources as described in this Policy or allowed by state law, patients with Family Income at and below 400% of FPG may qualify for Financial Assistance:

1. Patients whose Family Income is at or below 200% of the FPG are eligible to receive Emergency Medical Care or Medically Necessary Services at no charge; and
2. Patients whose Family Income is above 201% but not more than 400% of the FPG are eligible to receive a discount for Emergency Medical Care or Medically Necessary Services as outlined in the table below. Patients eligible for Financial Assistance will not be charged more than the AGB:

Family Income as % of FPG	Uninsured Patient Responsibility (% of AGB)	Underinsured Patient Responsibility (% of Patient's Cost Sharing)
up to 100%	\$0	\$0
up to 200%	\$0	\$0
201% to 250%	5% of the rate	5%
251% to 300%	10% of the rate	10%
301% to 350%	15% of the rate	15%
351% to 400%	20% of the rate	20%

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### 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<sup>1</sup> 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.



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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.

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<sup>1</sup> "Primary languages" includes any language that is used to communicate in at least 5% of patient visits per year, or demographic information available from the United States Bureau of the Census, supplemented by data from school systems.

## 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.

\$
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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	Date
Relationship to Patient	
Signature	

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### Exhibit 3

Patient Name: \_\_\_\_\_

Account Number(s): \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_

Date: \_\_\_\_\_

Dear Patient/Guarantor:

A request has been made that you be evaluated for Financial Assistance on your Richmond University Medical Centers' bill. Consideration for assistance will be based solely on your ability to pay for non-elective services within the guidelines of the poverty income guidelines.

All sources of payment must be exhausted before financial assistance is considered. Examples of payments would be all medical insurance, third party, and liability claims. Should you qualify for financial assistance, you will be responsible for any patient convenience items.

To process this request for assistance, please complete this financial assistance application and provide the following information:

1. Proof of identity – government issued identification (one form required)
1. Driver's license - State identification card – Passport - Military identification card
2. Registration card – permanent resident
3. Marriage certification (if applicable)
4. Birth, baptismal or citizenship certification (when applicable)
5. Mail addressed to patient or guarantor
6. Proof of income

## Richmond University Medical Center

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1. Wages and salaries
2. Paycheck stubs from the most current period
3. Receipts from self-employment
4. Regular payments from Public assistance, Social Security Administration, Unemployment, Alimony, child support, veterans' benefits, Workers' compensation, etc.

If you are unable to provide any of the requested information, please attach a NOTARIZED letter explaining the details of where you are from, how long you have lived in New York City with your current address and a statement attesting to the fact that you have no income or are unable to pay for the services rendered. If you are currently unemployed, please include the date you left employment, why you left, and the date you plan on returning to work.

If you need help or more information, please call us at (718) 818-2330 or (718) 818-2290. Please return your information in the enclosed postage paid envelope.



FINANCIAL ASSISTANCE WORKSHEET

ELIGIBILITY DETERMINATION

Exhibit 4

Effective from \_\_\_\_\_ to \_\_\_\_\_

Date Application Received \_\_\_\_\_ Hospital/Clinic Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Account Number(s): \_\_\_\_\_ Total Balance: \$ \_\_\_\_\_

Income/Family Composition Verified: \_\_\_ Yes \_\_\_ No

Type of Verification: \_\_\_\_\_ Pay Stubs \_\_\_\_\_ Other (specify below)

Situational / Summary Information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I recommend the applicant be approved for care at no charge. Amount provided under Financial Assistance is \$ \_\_\_\_\_.

I recommend the applicant be approved for care at a reduction of \_\_\_\_\_% of allowable charges. Amount provided under Financial Assistance will be responsible for \$ \_\_\_\_\_ and the patient/guarantor will be responsible for \$ \_\_\_\_\_.

Condition(s) if applicable: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Determination made by: \_\_\_\_\_ Date: \_\_\_\_\_

**Review and Approval Section**

The applicant's request for Financial Assistance has been denied for the following reason(s).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The applicant's request for Financial Assistance has been approved.

Reviewed and Approved by: \_\_\_\_\_

Signature

Title

Date

**Richmond University Medical Center**

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**Exhibit 5**

Patient Name: \_\_\_\_\_

Account Number(s): \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_

Date:

Dear Patient/Guarantor:

Richmond University Medical Center is currently in the process of evaluating you for Financial Assistance, in order to make our decision additional information is required.

Please provide copies of the following items:

- \_\_\_ Paycheck/unemployment check stubs or written statement of earnings from your employer.
- \_\_\_ Forms approving or denying unemployment, Workers Compensation or Assistance from the Department of Public Aid
- \_\_\_ Statement of monthly benefits from Social Security
- \_\_\_ Checking / Savings account statements
- \_\_\_ Identification
- \_\_\_ Other: \_\_\_\_\_

Please mail to:

***Failure to return the required information within (20) days may result in your application being denied.***

Sincerely,

Financial Counselor

## Richmond University Medical Center

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### Denial Notice

#### Exhibit 6

Patient Name: \_\_\_\_\_

Account Number(s): \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_

Date: \_\_\_\_\_

Dear Patient/Guarantor:

Richmond University Medical Center provides quality health care to meet the needs of all the people in the community it serves. Upon request, we will process applications for financial assistance from individuals who feel they are unable to pay for services rendered. Occasionally, we must deny a request by a patient that does not meet the required eligibility criteria.

Your request for financial assistance at Richmond University Medical Centers has been reviewed, your application is denied due to income levels that exceed the state poverty guidelines. However, we have another alternative to help you pay for the services received.

Richmond University Medical Center will offer you a payment plan for the total amount of your outstanding balance due. No interest will be charged to your account. However, failure to meet the guidelines specified may result in your account being subject to further collection procedures.

If you would like to establish a payment plan with us, Richmond University Medical Centers will hold your account(s) for \_\_\_\_ months, interest fee for equal monthly payments of \$\_\_\_\_\_ to be paid by the \_\_\_\_\_ of each month.

Please contact us at ( ) \_\_\_\_ - \_\_\_\_\_ to make payment arrangements that are acceptable. Your prompt attention to this matter is greatly appreciated. Failure to contact our office to make suitable payment arrangements within fifteen (15) days may result in further collection activity.

Sincerely,

Financial Counselor

**Richmond University Medical Center**

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Approval Notice

**Exhibit 7**

Date: \_\_\_\_\_

Dear Patient/Guarantor:

Richmond University Medical Center has reviewed your application for financial assistance. Based on the information you provided, the hospital has determined that you are eligible for assistance. Listed below are the self-pay portions minus the eligible percentage of assistance that we will provide.

ACCOUNT NUMBER	SELF-PAY PORTION	AMOUNT OF ASSISTANCE	PATIENT RESPONSIBILITY
1.			
2.			
3.			
4.			
5.			
TOTAL			

We would appreciate payment in full by \_\_\_\_\_. RUMC accepts credit cards (Visa, MasterCard, Discover and American Express), checks, money orders and cash. To pay by credit card fill in the bottom section of this letter. If you are unable to make payment in full, please call and we can assist you by setting up a payment plan within the hospitals guidelines. Please call us at \_\_\_\_\_ - \_\_\_\_\_

We have already discussed a payment plan and \$ \_\_\_\_\_ is due by \_\_\_\_\_.

Sincerely,

Financial Counselor



**Richmond University Medical Center**

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**Exhibit 2**

