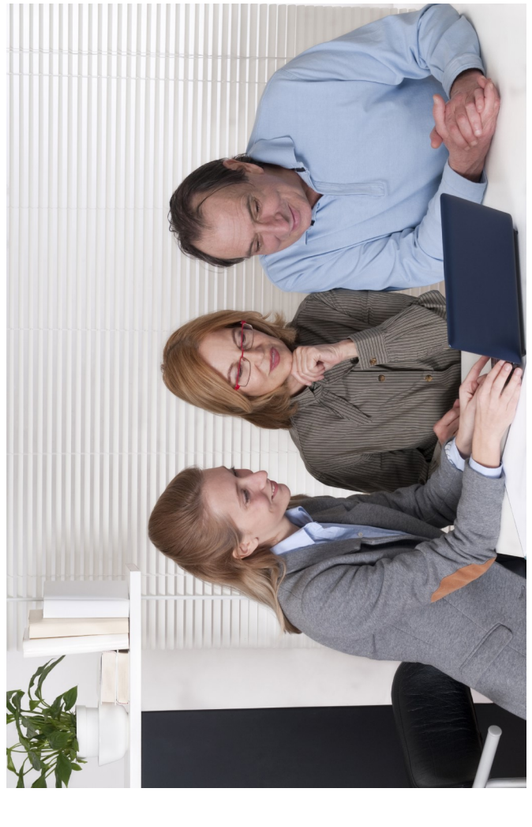
Financial Assistance Policy and Application



A helpful resource for patients in need of financial assistance

Bassett Healthcare Network
Cobleskill Regional Hospital

2022

Bassett Healthcare Network
Cobleskill Regional Hospital

178 Grandview Drive
Cobleskill, NY 12043
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www.bassett.org

Cobleskill Regional Hospital
Financial Assistance Policy and Application
August 2022

Cobleskill Regional Hospital's Financial Assistance Policy provides free or discounted care to uninsured and underinsured individuals and families who have difficulty paying for the total cost of their medical care, including emergency medical treatment. Emergency medical treatment and medically necessary services are provided in all cases, regardless of an individual's inability to pay. So that we are able to serve as many people as possible under this program, applicants must meet certain eligibility requirements. All Bassett Healthcare patients may apply for the Financial Assistance program regardless of the location of their residence. This is not a health insurance policy and does not meet the criteria for a qualified health plan under the Affordable Care Act. We strongly encourage and offer assistance in applying for long term insurance coverage if determined eligible. The application is only valid for the approved timeframes specified below. Separate applications are available for each Bassett Healthcare Network Hospital.

What services are not covered by this policy?

Services provided at Cobleskill Regional Hospital by non-Bassett physicians or other third-party healthcare providers. Currently all physician services performed at Cobleskill Regional Hospital are covered under this policy. You may contact the hospital at (607) 547-3480 or 1-800-642-0455, or visit www.bassett.org if you have questions as to whether your physician services are covered by this policy.

Services excluded from the Financial Assistance Program are:

- Pharmacy
- Eyewear/Contact Lens
- Hearing Aids and Durable Medical Equipment
- Routine Dental Care (first dentures post extraction are covered)
- Oral Surgery
- Cosmetic Surgery
- Any date of service more than two hundred forty (240) days prior to the mailing of the first post-discharge statement

What are the qualifications for financial assistance?

To qualify for financial aid through the Financial Assistance Program, the services and application must meet the following requirements:

- Financial assistance applications will be accepted for future services within 60 days following the application date, limited to scheduled services not excluded from the program. Prior services not more than 240 days from the date of mailing of the first post discharge statement are also eligible.
- Your family's annual, gross household income does not exceed 300% of the following federal poverty limits (FPL) and you are uninsured* or your family's annual, gross household income does not exceed 200% of the following federal poverty limits (FPL) and you are insured*

Poverty Level*	***Un*insured and at or below 300%**				***Under*insured and at or below 200% of FPL**	
Discount	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Household Size	**Income Level (FPl)**	**200%**	**250%**	**300%**	**Income Level (FPl)**	**200%**
1	$13,590	$27,180	$33,975	$40,770	$13,590	$27,180
2	$18,310	$36,620	$45,775	$54,930	$18,310	$36,620
3	$23,030	$46,060	$57,575	$69,090	$23,030	$46,060
4	$27,750	$55,500	$69,375	$83,250	$27,750	$55,500
5	$32,470	$64,940	$81,175	$97,410	$32,470	$64,940
6	$37,190	$74,380	$92,975	$111,570	$37,190	$74,380
7	$41,910	$83,820	$104,775	$125,730	$41,910	$83,820
8	$46,630	$93,260	$116,575	$139,890	$46,630	$93,260
For each additional person, add	$4,720	$9,440	$11,800	$14,160	$4,720	$9,440

Note: Any uninsured applicant that has verified income below the 300% of the federal poverty limit (FPL) is eligible for financial assistance as long as all program requirements are met.

While all applicants are required to complete all sections of the application and meet all program requirements, Cobleskill Regional Hospital reserves the right, in its sole discretion, to waive application requirements for sufficient cause shown consistent with applicable federal and state law.

How do I apply for financial assistance?

An application for financial assistance requires:

- A fully completed, signed and dated application (included).
- All applicants may disregard any billings received during the period following the submission of their application until a final decision has been made concerning eligibility.
- Verification of income. Please provide documentation of your income with your application. Commonly used documentation include pay stubs or benefits statements. You may provide, but are not required to substantiate your income with your tax return. In the event of recent changes to your income (due to loss of employment, etc.) you may submit additional verification of income for the six month period immediately prior to the date of the application. Please note if you are self employed and have submitted a tax return, there may be some deductions that may not be considered when calculating your income and eligibility for this program.

How will I know if I was approved for financial assistance?

A Financial Assistance Determination letter will be mailed to you within 30 days after the completion and submission of all required documentation, telling you of our determination of your application. An approved application for financial assistance will create a lien in favor of Cobleskill Regional Hospital against the proceeds of any personal injury lawsuit or claim related to the hospital services listed in the application. Financial assistance policy will be applied to any remaining charges, copays, deductibles after insurance payments and settlements are paid.

Can I appeal a denial of financial assistance?

Denials of financial assistance may be appealed within 30 days of the denial date by submitting a written statement of appeal with any supporting materials to:

Financial Assistance Program
Bassett Healthcare Network
Attention: Financial Assistance Appeal
One Atwell Road
Cooperstown, NY 13326

What other programs are available?

New York has several government sponsored insurance programs including, but not limited to Medicaid, Child Health Plus, Healthy NY and Prenatal Care Assistance (PCAP). Information and a complete list of programs can be found at ***http://www.health.state.ny.us.*** You may also contact your county Department of Social Services for information on these programs. Information on the available health plans offered through the New York State Health Exchange may be found at: ***http://www.nystateofhealth.ny.gov*** or by calling 1-855-355-5777 (toll free).

Who do I contact for more information or assistance with my application?

Applications can be downloaded from www.bassett.org by clicking on “Financial Assistance” and selecting the appropriate Bassett Healthcare Network facility. Contact Bassett Medical Center Account Representatives at (607)-547-3093 or 1-(800)-642-0455 (toll free) for further information or to request a free copy of the policy and application, or to apply. A completed application with supporting materials should be sent to:

Financial Assistance Program
Bassett Healthcare Network
One Atwell Road
Cooperstown, NY 13326

What options are available to me if I am not eligible for financial assistance?

Billing and Collection Policy: At any time within 240 days after the first statement is mailed, an eligible responsible party may complete an application for our Financial Assistance Program.

We, as well as our billing and collection partners, make every reasonable effort to assist patients and responsible parties to resolve their outstanding balances. All responsible parties will receive billing statements subsequent to referral of the account to the hospital’s self pay billing agency. Should the responsible party be unable to remit full payment of the outstanding balance, the responsible party may enter into an approved interest free monthly installment payment arrangement. All approved installment payment arrangements will be confirmed with the responsible party in writing.

Definitions:

- **Uninsured:** Not covered by insurance
- **Underinsured:** Inadequately covered by insurance
- **Family:** Using the Census Bureau definition, a group of two or more people who live together and are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the Financial Assistance Policy.
- **Household:** Household, as it relates to household income, defined by the Census Bureau will include any person living in the household over the age of 15
- **Household Income:** Household Income is determined by using the Census Bureau definition, which uses the following income sources:
  - ♦ Earnings/wages, unemployment compensation, workers’ compensation, Social Security, Supplemental Security Income, public assistance, veterans’ payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
  - ♦ Non-cash benefits (such as food stamps and housing subsidies) do not count;
  - ♦ Determined on a before-tax basis;
  - ♦ Excludes capital gains or losses; and
  - ♦ If a person lives with a family, includes the income of all family members who live together as part of a single-family unit. A roomer or boarder is not included.

APPLICATION FOR HEALTH CARE SERVICES UNDER THE FINANCIAL ASSISTANCE PROGRAM

APPLICANT NAME: _____ DATE OF APPLICATION: _____

DATE OF BIRTH: _____/_____/_____ PHONE: ( ) _____

STREET ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____

MARITAL STATUS (circle one): Married Single Divorced Widowed Legally Separated (must provide proof)

SPOUSE NAME: _____ DATE OF BIRTH: _____/_____/_____

EMPLOYER (Applicant): _____

EMPLOYER (Spouse, if applicable): _____

FAMILY SIZE (Including applicant): _____ FAMILY HOUSEHOLD INCOME BEFORE TAXES: (Last 6 months) $_____

AGES OF CHILDREN: _____

VERIFICATION OF INCOME: ☐ Paystub(s) ☐ Tax Return(s) ☐ Benefit Statement(s) ☐ Other (specify): _____

***Proof of income can include one or more of the following: copies of paystubs, current State and Federal Tax Returns, Benefit Statements or documentation of any other income with your application.**

EMPLOYER SPONSORED OR OTHER INSURANCE:

Do you or your spouse have access to employer-sponsored or other health insurance? ☐ YES ☐ NO

If yes, estimated monthly cost of employer-sponsored/other health insurance: _____

If yes, name, address and phone number of employer/other agency offering health insurance:

_____

***Please attach supporting documentation verifying costs, options available and enrollment.**

LIABILITY CLAIMS: Has a lawsuit or other claim based on these services been commenced, or is a lawsuit or claim contemplated?

☐ Yes / ☐ No

If Yes, please provide Attorney’s Name and Address: _____

_____

Name and Address of the person(s) responsible: _____

_____

I certify that the above information is true and complete, to the best of my knowledge. I understand that assistance is available through Bassett Healthcare Network to help me with pending applications for financial assistance or third-party coverage (Medicaid, Medicare, Insurance, etc.) If those options are available for payment for these hospital and/or physician charges, I understand I should take any action reasonably necessary to obtain such assistance. If I am awarded any proceeds from third-party coverage such as an accident settlement or civil case, I will assign those proceeds to the hospital regardless of when the payment is received. However, any such payment or lien is only to the extent of these charges, or any such recovery, whichever is less.

By making this application, I hereby grant a lien to Cobleskill Regional Hospital on the proceeds of any recovery paid to me, or in my benefit, or the patient, or the patient’s benefit, as a result of any civil action, arbitration, or claim related to these charges. Applicant(s) hereby authorize Cobleskill Regional Hospital to conduct a reasonable investigation into the availability of employer-sponsored health insurance, including communication with applicants’ employers.

If any information I have provided in connection with this application is later determined to be incorrect or incomplete, eligibility for the Financial Assistance Program will be re-evaluated based on the correct or additional information, and I may be held responsible for payment of any services previously considered eligible under the Financial Assistance Program.

Signature: _____ Dated: _____/_____/_____

Spouse: _____ Dated: _____/_____/_____

Bassett Healthcare Network

4681 1/10;4/10;2/11;2/12;2/13;3/14;3/15;3/16;8/16;3/17;2/18;2/19 ;2/20;5/21;2/22;8/22