Richmond University Medical Center

Department: Finance/Patient Access/Central Business Office	**Policy Description:** RUMC Financial Assistance
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Approved:	**Retired:**
Effective Date: January 2007 **Revised: January 2021**	**Reference Number:**

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.

Patients with insurance are required to file a claim with their insurance carrier. Patient's refusing to file a claim with their insurance are not eligible for RUMC's Financial Assistance Program. Patients are eligible for Financial Assistance for balances remaining after all insurances are filed and paid.

Based on patient's family size, patients with an income of up to 400% of the Federal Poverty Guideline will be eligible for some type of discount on their hospital bill.

PURPOSE: To establish guidelines for processing Financial Assistance Applications in a fair, timely and effective manner.

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 be based solely on the patient's ability to pay and will not be based on age, sex, race, creed, religion, disability, sexual orientation, national origin, handicap, marital or veteran status.

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 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 payor 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 Payment Plans.

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 (FAP) rate. See attached Financial Assistance Reduced Fee Schedules – Exhibits #1 Income Guidelines including Clinic Flat Fees Schedule

7. This Financial Aid 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.

8. **HOSPITAL BASED CHARGES**

Group #1 100% write-off - No bill sent to the patient

Group #2 90% write-off - Patient pays 10%

Group #3 80% write-off - Patient pays 20%

Group #4 60% write-off - Patient pays 40%

Group #5 40% write-off - Patient pays 60%

Group #6 20% write-off - Patient pays 80%

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.

ELIGIBILTY:

1. Patient Access and the Central 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.

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 a vendor that are subsequently denied, may be eligible for the FAP. 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 after the services were rendered.

2. RUMC Patient Access and the Central Business Office along with third party professional collection agencies or other agents of RUMC will administer this Financial Assistance policy.

3. Financial Assistance may be requested by the patient or the patient's advocate.

4. Anyone making a request for Financial Assistance may obtain an application from the RUMC, which includes instructions on how to apply.

5. Consideration for financial assistance will occur once the applicant completes and signs the application and submits it with the appropriate documents except in the case where a Medicaid application was previously completed and denied.

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. Special approval for additional allowances may be made for extenuating circumstances by the Vice President of Revenue Cycle.
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 a time frame for submitting the missing information. Patients are requested to provide information within thirty (30) days to submit a completed application which 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 anytime 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 NYU Radiology

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 Patient Financial Services at the Central Business Office 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 and 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 #3) with a RUMC Financial Assistance cover letter (Exhibit #4) 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 the Medicaid Application Specialist and obtain family size from page 2, income levels from pages 6 and 7 along with family expense information from page 10 of 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.

7. 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.

8. 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)

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

11. Proof of income is required and will be verified. Items listed below need to be copied and attached to the Financial Assistance Application.

   a. If unemployed, a notarized letter from the patient/guarantor documenting all facts supporting the need for assistance and a letter form the person that is supplying basic needs.

   b. If employed, for wages and salaries one or more of those items listed below should be included for proof of income.

      1. Paycheck stubs from the most current period.

      2. Receipts from self-employment or from a business after business expenses.

      3. Regular pay stubs showing payments from:

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

12. Copies of a current bank account statements for all checking and savings accounts.

13. Note the following information on the Financial Assistance Log for the appropriate month:
    a. Date application was given to patient/guarantor
    b. Patient name
    c. Account number(s)
    d. Balance due

14. The Financial Counselor must document all activity in the system, receive the patient's completed Financial Assistance application and complete the following:
    a. Create a patient folder to store all documents
    b. Enter the date the application was received on the Financial Assistance Log

c. Document activity in the system

Authorization Levels	Approval Range
Manager	$00.00-$500.00
Director of Pt Access/Manager	$501.00 - $10,000.00
Asst.Vice President of Patient Access/CBO	$10,001.00 - $50,000
EVP / CFO	$50,001.00 and above

d. 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.

1. If complete, proceed to step #15.

2. If incomplete proceed to step #18b.

15. Complete the top section of the Financial Information Worksheet (Exhibit #6).

a. Review and evaluate the information to make a Financial Assistance recommendation

1. Determine gross yearly income amount.

2. Determine size of family and poverty guideline amount from the RUMC Financial Assistance Reduced Fee Schedule / Federal Poverty Guidelines (Exhibit #1 or #2a & 2b) based on the sliding scale; establish the appropriate assistance percentage, if any that will be given.

3. Make a recommendation for approval or denial and write a brief summary on the worksheet.

16. 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.

17. The Manager will review and make a final determination after reviewing the documents:

    a. If denied, the Supervisor will document reason, sign the form and return to the Financial Counselor. Proceed to step #18.

    b. 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.

18. The Financial Counselor will receive denial and complete the following steps:

    a. If patient does not qualify for Financial Assistance, go to step # 19.

    b. If the patient does not quality because additional information is required,

        1. Send the patient a 'Request for Additional Information' letter (Exhibit #7).

        2. Document activity in the system and on the Financial Assistance Log

        3. Place the application in the 'Pended' file

    c. Review 'Pended' files weekly, if information has not been received:

        a. Make two (2) attempts to contact the patient/guarantor

        b. If unsuccessful, determine the case to be a denial and proceed to next step.

19. Send the patient a 'Denial Notice' (Exhibit #8). Or if this is a clinic visit, inform the patient.

    a. Document activity in the system and on the Financial Assistance Log.

    b. Place the original documents in the Financial Assistance Completed File (alphabetized). Process is complete unless the patient appeals.

20. Once approval is received, the Financial Counselor should complete the following steps:

a. If the patient received a discount of 100%:

   1. Send the patient/guarantor an Approval Notice (Exhibit #9) – clinic patients may be notified in person.

   2. Request an adjustment for the full amount

   3. Document activity in the system and on the Financial Assistance Log.

   4. Place the original documents in the Financial Assistance Completed File (alphabetized) "Process Completed"

b. If partial discount has been approved and the patient is responsible for a percentage of the balance:

   1. Inform the party of the discounted amount in person or via phone call.

   2. Arrange to have the balance paid in full or set up payment arrangements.

   3. Send the patient an Approval Notice and Payment Agreement.

   4. Place the file in the 'Approved' file pending payment.

   5. Document activity in the system.

21. The Financial Counselor will receive payment and a payment agreement when required from patient/guarantor:

   a. The Financial Counselor should pull pended file.

   b. Set up payment arrangement in system if needed.

   c. Request adjustment for Financial Assistance.

   d. Document activity in the system and on the Financial Assistance Log.

   e. Place the original documents in the Financial Assistance completed file (alphabetized until the application process is complete.

22. The Financial Counselor should weekly review each application in the pended file:

   a. If payment in full has been received proceed to step #21

b. If payment is not received within three (3) weeks, make two (2) attempts to contact the patient. If no response, return to step #19.

23. At the end of each month:

a. E-mail your Request for Financial Assistance Log to your Supervisor/Manager/Director, which will include the monthly summary section.

b. The Director will compile all statistics from the logs into one (1) report and distribute to the 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. Behavioral Health OP Fee Schedule Staten Island
3. Financial Assistance Application
4. Financial Assistance Cover Letter
5. Request for Financial Assistance Log
6. Financial Assistance Worksheet
7. Request for Additional Information Letter
8. Denial Notice
9. Approval Notice

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REFERENCE

RUMC Self-Pay Payment Policy & Procedure

RICHMOND UNIVERSITY MEDICAL CENTER

FINANCIAL ASSISTANCE REDUCED FEE SCHEDULE

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

SIZE OF FAMILY	GROUP #1 INCOME BELOW	GROUP #2 INCOME BETWEEN	GROUP #3 INCOME BETWEEN	GROUP #4 INCOME BETWEEN	GROUP #5 INCOME BETWEEN	GROUP #6 INCOME BETWEEN
1	$12,880	$12,881-$19,320	$19,321-$25,760	$25,761-$32,200	$32,201-$38,640	$38,641-$51,520
2	$17,420	$17,421-$26,130	$26,131-$34,840	$34,841-$43,550	$43,551-$52,260	$52,261-$69,680
3	$21,960	$21,961-$32,940	$32,941-$43,920	$43,921-$54,900	$54,901-$65,880	$65,881-$87,840
4	$26,500	$26,501-$39,750	$39,751-$53,000	$53,001-$66,250	$66,251-$79,500	$79,501-$106,000
5	$31,040	$31,041-$46,560	$46,561-$62,080	$62,081-$77,600	$77,601-$93,120	$93,121-$124,160
6	$35,580	$35,581-$53,370	$53,371-$71,160	$71,161-$88,950	$88,951-$106,740	$106,741-$142,320
7	$40,120	$40,120-$60,180	$60,181 - $80,240	$80,241 - $100,300	$100,301 - $120,360	$120,361 - $160,480
8	$44,660	$44,660-$66,990	$66,991 - $89,320	$89,321 - $111,650	$111,651 - $133,980	$133,981 - $178,640

For family units with more than eight family members add $4,540 for each additional member.

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

	HOSPITAL BASED CHARGES	**CLINIC FLAT FEES**
	Includes Inpatient, Outpatient, Emergency Department, Outpatient Surgery, etc.	*Includes all services provided by the Clinics - includes basic tests*
Group #1	100% write/off - No bill to patient	Patient pays - $ 0
Group #2	90% write/off – Patient pays 10%	Patient pays - $15.20
Group #3	80% write/off - Patient pays 20%	Patient pays - $30.40
Group #4	60% write/off - Patient pays 40%	Patient pays - $60.80
Group #5	40% write/off - Patient pays 60%	Patient pays - $91.20
Group #6	20% write/off - Patient pays 80%	Patient pays - $121.60

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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.

Effective: January 1, 2021

RUMC - BEHAVIORAL HEALTH

Exhibit #2A

OUTPATIENT CLINIC/DAY PROGRAM

STATEN ISLAND

SLIDING FEE SCHEDULE

GROSS ANNUAL

		NUMBER OF DEPENDANTS						
HOUSEHOLD INCOME		**1**	**2**	**3**	**4**	**5**	**6**	**7+**
		Patient Pays	Patient Pays	Patient Pays	Patient Pays	Patient Pays	Patient Pays	Patient Pays
$0 - $ 7,500	Individual	$ 12						
	Group	$ 11						
$7,501 - $10,000	Individual	$ 16	$ 12					
	Group	$ 14	$ 11					
$10,001 - $12,500	Individual	$ 20	$ 16	$ 12				
	Group	$ 18	$ 14	$ 11				
$12,501 - $15,000	Individual	$ 24	$ 20	$ 16	$ 12			
	Group	$ 21	$ 18	$ 14	$ 11			
$15,001 - $17,500	Individual	$ 28	$ 24	$ 20	$ 16	$ 12		
	Group	$ 25	$ 21	$ 18	$ 14	$ 11		
$17,501 - $20,000	Individual	$ 32	$ 28	$ 24	$ 20	$ 16	$ 12	
	Group	$ 28	$ 25	$ 21	$ 18	$ 14	$ 11	
$20,001 - $25,000	Individual	$ 38	$ 32	$ 28	$ 24	$ 20	$ 16	$ 12
	Group	$ 31	$ 28	$ 25	$ 21	$ 18	$ 14	$ 11
$25,001 - $30,000	Individual	$ 46	$ 38	$ 38	$ 32	$ 28	$ 24	$ 20
	Group	$ 35	$ 31	$ 31	$ 28	$ 25	$ 21	$ 18
$30,001 - $35,000	Individual	$ 50	$ 46	$ 38	$ 38	$ 32	$ 28	$ 24
	Group	$ 38	$ 35	$ 31	$ 31	$ 28	$ 25	$ 21
$35,001 - $40,000	Individual	$ 55	$ 50	$ 46	$ 38	$ 38	$ 32	$ 28
	Group	$ 41	$ 38	$ 35	$ 31	$ 31	$ 28	$ 25
$40,001 - $45,000	Individual	$ 60	$ 55	$ 50	$ 46	$ 38	$ 38	$ 32
	Group	$ 45	$ 41	$ 38	$ 35	$ 31	$ 31	$ 28
$45,001 - $50,000	Individual	$ 65	$ 60	$ 55	$ 50	$ 46	$ 38	$ 38
	Group	$ 48	$ 45	$ 41	$ 38	$ 35	$ 31	$ 31
$50,001 - $55,000	Individual	$ 70	$ 65	$ 60	$ 55	$ 50	$ 46	$ 38

	Group	$ 51	$ 48	$ 45	$ 41	$ 38	$ 35	$ 31
$55,001 - $60,000	Individual	$ 75	$ 70	$ 65	$ 60	$ 55	$ 50	$ 46
	Group	$ 55	$ 51	$ 48	$ 45	$ 41	$ 38	$ 35
$60,001 - $65,000	Individual	$ 82	$ 75	$ 70	$ 65	$ 60	$ 55	$ 50
	Group	$ 58	$ 55	$ 51	$ 48	$ 45	$ 41	$ 38
$65,001 - $70,000	Individual	$ 89	$ 82	$ 75	$ 70	$ 65	$ 60	$ 55
	Group	$ 61	$ 58	$ 55	$ 51	$ 48	$ 45	$ 41
$70,001 - $75,000	Individual	$ 98	$ 89	$ 82	$ 75	$ 70	$ 65	$ 60
	Group	$ 65	$ 61	$ 58	$ 55	$ 51	$ 48	$ 45
$75,001 - OVER	Individual	$ 107	$ 98	$ 89	$ 82	$ 75	$ 70	$ 65
	Group	$ 68	$ 65	$ 61	$ 58	$ 55	$ 51	$ 48

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Richmond University Medical Center

Initial Application

Please Print

Patient's Name:_____

Hospital/Clinic & Account Number(s): _____

Type of Service: _____Clinic ___Emergency ___Inpatient

Address	City/State/Zip	Telephone #	Cell Phone or Other Contract (Name & Phone #)
Date of Birth	SS # (Optional)	Employer	Address / Phone #
If minor – Parent's Names	SS # (Optional)	Employer	Address / Phone #
Family Members:	Dates of Birth:	SS # (Optional)	Family's Annual Income

_____OP Surgery ____Other

Situational Information / Please describe you current financial situation / hardships:

_____

_____

_____

Applicant Statement:

I certify that the above information is correct. I understand that the information, which I submit, is subject to verification by Richmond University Medical Center and subject to review. Further, I will take all steps necessary to apply for any assistance (Medicaid, Medicare,

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Insurance, etc.), which may be available for payment of my hospital charge. I will take any action reasonably necessary to obtain such assistance and will assign or pay the hospital the amount recovered for hospital charges. I understand that if any of the information I have given proves to be untrue, the hospital may re-evaluate my financial status and take whatever action it deems appropriate.

Signature (Patient or Guarantor) _____ Date _____

Print Name _____ Relationship to Patient _____

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Richmond University Medical Center

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

   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.

Richmond University Medical Center

FINANCIAL ASSISTANCE WORKSHEET

ELIGIBILITY DETERMINATION

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

Department: Finance/Patient Access/Central Business Office	**Policy Description:** RUMC Financial Assistance
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Approved:	**Retired:**
Effective Date: January 2007 **Revised: January 2021**	**Reference Number:**

Richmond University Medical Center

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)
2. Drivers license - State identification card – Passport - Military identification card
3. Registration card – permanent resident
4. Marriage certification (if applicable)
5. Birth, baptismal or citizenship certification (when applicable)
6. Mail addressed to patient or guarantor
7. Proof of income
8. Wages and salaries
9. Paycheck stubs from the most current period
10. Receipts from self-employment
11. Regular payments from Public assistance, Social Security Administration, Unemployment, Alimony, child support, veterans' benefits, Workers' compensation, etc.

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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.

Richmond University Medical Center

FINANCIAL ASSISTANCE WORKSHEET
ELIGIBILITY DETERMINATION

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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Richmond University Medical Center

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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Richmond University Medical Center

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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Richmond University Medical Center

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

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Richmond University Medical Center

P.O. Box 11565

Newark, NJ 07101-4565

Account #:_____

Patient Name: _____

Payment: **$_____**

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit Card payments, please complete this section:

Card # _____ Exp Date ____/____

CARD HOLDER'S NAME _____Amount Authorized $_____

Signature _____