**Policy Description: Richmond University Medical Center (RUMC) – Financial Assistance Policy (FAP)**

**Department**: Finance/Patient Access/Revenue Cycle **Effective Date**: January 2007 **Revised Date**: April 2025

**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 200% of the Federal Poverty Level is full charity care and from 201% - 400% of the Federal Poverty Level will be eligible for a discount on their hospital bill based upon group 3-6 of our hospital based charges.

**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.

**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 income between 201% - 400% 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 hospital based 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. 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 and 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.
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%

1. 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.
2. Patients may apply/re-apply for financial assistance at any time when their personal financial situation changes.

**ELIGIBILTY:**

1. Patient Access, the Financial Assistance & the Business Office’s 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 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 Eligibility Specialist will review the Medicaid application and if adequate information is available, the Eligibility Specialist may submit the information for approval based on the patient’s financial situation.
8. Any collection agency or accounts receivable vendor under contract with RUMC will be required to follow RUMC’s Financial Assistance policies and to provide patients with information on how to apply for the program.

**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.
6. Consideration for Financial Assistance Program includes a review of the responsible party’s annual household income and number of people in the home. 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 and/or the Chief Financial Officer 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**

Professional bills from provider groups are excluded from FAP, including but not limited to Anesthesia and 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 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.

**PROCEDURE:**

1. The Eligibility Specialist will document all activity on the patient’s account. Then obtain a request for financial assistance from the patient.The Eligibility Specialist will review the patient’s information for possible third party coverage and/or other self-pay options and/or a payment plan.

1. 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:
	1. 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
	2. Refer the patient/guarantor to an on-site Eligibility Specialist or direct the party to a Medicaid location where they can apply.
2. Advise the patient/guarantor to notify the Hospital immediately when they receive notification from Medicaid:
3. If the patient receives Medicaid approval, the Eligibility Specialist will input the Medicaid billing data, change the insurance plan to Medicaid, and refer the account to billing and document activity in the system. The account will be billed to Medicaid.
4. 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 Eligibility Specialist. A Financial Assistance application with a RUMC Financial Assistance cover letter will be given or mailed to the party to begin the process.
5. 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 Eligibility Specialist will review and obtain family size, income levels and family expense information from the application. Using this information, the Eligibility Specialist 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.
6. 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:
7. The Financial Assistance application must be completed and returned with all completed documentation within twenty (20) days.
8. **Failure to provide the information listed below may cause the patient’s Financial Assistance Application to be denied.**
9. The Eligibility Specialist is available to assist in filling out the form if needed, and the Hospital can make copies of the required documents if the patient is unable to do so.
10. **Please do not** mail original documents.

1. Eligibility requirements will be based upon a combination of the following criteria:
	1. Family income
	2. Number of dependents in family (Family members are defined as persons occupying the same household and who are identified as dependents for tax purposes).
	3. Patients who have health insurance and have spent more than 10% of their income on out-of-pocket medical expenses offered by RUMC and its salaried physicians, not including insurance premiums
	4. Other hardships.
	5. Proof of New York State Residency (i.e. driver’s license, utility bill, bank statement or cell phone etc. 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 Eligibility Specialist 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 or more form(s) of identification is required):
			1. Driver’s License
			2. State Identification Card
			3. Passport
			4. Military Identification Card
			5. Registration Card (Permanent Resident - when applicable)
			6. Marriage Certificate (when applicable)
			7. Birth, Baptismal or Citizenship Certification (when applicable)
			8. Mail addressed to patient/guarantor
2. 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, the patient must supply a statement of unemployment and must be notarized. A letter from the person supporting the patient documenting all facts that they are supplying basic needs to the patient, such as room and board and meals etc. This letter does not need to be notarized.
	2. 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 employer.
		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 payment
3. Note the following information on the Financial Assistance Log/Report for the appropriate month:
	1. Date application was given to patient/guarantor
	2. Patient name
	3. Account number(s)
	4. Balance due
4. The Eligibility Specialist 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
	3. Document activity in the hospital system
	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.

|  |  |
| --- | --- |
| **Authorization Levels** | **Approval Range** |
| 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 |

9. Complete the top section of the Financial Information Worksheet.

1. 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 Level 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.
		3. Make a recommendation for approval or denial and write a brief summary on the worksheet
2. The Eligibility Specialist 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.
3. 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 Eligibility Specialist.
	2. If approved, the Supervisor will sign and date the Financial Information Worksheet and return it with all the financial documentation to the Eligibility Specialist.
4. The Eligibility Specialist will receive denial and complete the following steps:
	1. If patient does not qualify for Financial Assistance, a denial letter will be sent to patient
	2. If the patient does not quality because additional information is required,
		1. Contact the patient to inform them of the additional documents needed.
		2. Document activity in the system and on the Financial Assistance Log/Report
		3. 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.
5. Send the patient a Denial Letter. 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.
6. Once approval is received, the Eligibility Specialist should complete the following steps:
	1. If the patient received a discount of 100%:
		1. Send the patient/guarantor an Approval Notice.
		2. Notation entered on the initial visit being approved for FAS discount. An adjustment will be entered by the Business Office.
		3. Document activity in the system and on the Financial Assistance System.
		4. 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:
		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.
		4. Place the file in the ‘Approved’ file pending payment.
		5. Document activity in the system.
7. The Business Office will send the patient the appropriate billing statement and will be available `to answer questions. The patient can also set up a payment arrangement with the Business Office. The monthly payment plan will not exceed 5% of the patient’s income.
8. Credit Card Risk Notification (credit cards only, not debit cards)

**A Each** time a credit card is used to pay for services, patients must be notified of the risks of paying for medical services with a credit card, including:

* 1. Medical bills paid by credit card are no longer considered medical debt. ii. By paying with a credit card, patients are forgoing federal and state protections around medical debt.

B Protections that patients must acknowledge forgoing include:

* 1. Prohibitions against wage garnishment and property liens
	2. Prohibition against reporting medical debt to credit bureaus
	3. Limitations on interest rates

C Patients must affirmatively acknowledge forgoing these protections by paying with a credit card.

**VENDOR:**

The Eligibility Specialist and Vendor Manager will compile all statistics from the system into a monthly 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. NYS Uniform Hospital Financial Assistance Application
3. Financial Assistance Document Letter
4. Financial Assistance Eligibility Determination Letter Worksheet
5. Denial Notice
6. Approval Notice

**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***

**SIZE OF FAMILY GROUP #1 GROUP #2 GROUP #3 GROUP #4 GROUP #5 GROUP #6**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| % FPL 100% | 101% -200% |  201%-250% | 251%-300% | 301-350% |  | 350%-400% |
| 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-$12,4800  |
| 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 2025).** 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 Includes all services provided by the***

 ***Department, Outpatient Surgery, etc. Clinics* - *includes basic tests***

Group #1 100% write/off - No bill to patient pays - $ 0

Group #2 100% write/off – No bill to 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

**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

|  |  |  |
| --- | --- | --- |
| **Family Income as %of FPG** | **Uninsured Patient Responsibility (% of AGB)** | **Underinsured PatientResponsibility (% 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% |

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



**Exhibit 2**

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 primary1 languages spoken by patients served by the hospital.*

**Patient Name (complete information that is applicable)**

|  |
| --- |
| Patient Name (First, Middle, Last) |
| Date of Birth (mm/dd/yyyy) |
| Address | Apartment/Unit # |
| City | State | Zip |
| Contact Phone # |
| Parent/Guardian or Lawful Representative Name (if patient is a minor child or an incapacitated adult) |
| Email Address (if any) |

**Family Information:**

Please list below all family members in your household. Your household includes yourself, your spouse or domestic partner, and any children or other dependents. For example, this would include everyone listed on the same tax return.

Gross income means your income **before** taxes are deducted.

Gross income can consist of work earnings (wages, salaries, tips, earnings from self- employment), unearned income (social security, disability, and unemployment benefits), contributions (funds from family or friends), and other sources of income (temporary assistance and supplemental security income).

|  |  |  |
| --- | --- | --- |
| **Full Name** | **Relationship** | **Total Gross Income (Current)** |
|  | Self |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Full Name** | **Relationship** | **Total Gross Income (Current)** |
|  |  |  |
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**Health Insurance Status**

Do you have any form of health insurance, including Medicaid, Medicare, or private insurance through your employer or purchased on your own? Yes No

If you answered “No,” would you like assistance in applying for any of these programs?

 Yes No

**Underinsured patients: people with insurance and high medical expenses.** If you have insurance, please provide an estimate of the medical bills you paid in the past 12 months.

$

The hospital may request you submit documentation as proof of paid medical expenses.

**Patient/Responsible Party: If not the patient, list the name of the person signing the form and their authority to sign on behalf of the patient (e.g., spouse, parent, legal representative).**

I understand that the information I submit may be subject to verification from external sources. I certify that the information is true and complete to the best of my knowledge.

|  |  |
| --- | --- |
| Print NameRelationship to Patient | Date |
| Signature |

If you need any assistance completing or have any questions regarding this form, please contact our Eligibility Specialists at 718-818-2290 or 718-818-2289.

Rev 10/20/2024



**Financial Assistance Department – Exhibit 3**

 Rep. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_

THIS IS NOT A BILL**. ESTO NO ES UNA CUENTA.**

THIS IS A REQUEST FOR FINANCIAL ASSISTANCE DOCUMENTION. **ESTO ES UN PEDIDO PARA DOCUMENTACION PARA EL PROGRAMA DE ASISTENCIA FINANCIERA.**

Please bring the following documents with you in order to process your Medicaid application. We will be on the **LOBBY LEVEL RM# G69A** from 8:00am to 5:30pm Monday through Friday. Please call to set up an appointment to bring in documents. All documents must be ORIGINAL only. All documents must be reviewed by the Eligibility Specialist.

**Necessary Documents: *Please submit all (in each category)***

* + **Proof of Identification**

 Birth certificate, Passport, Driver’s license, State ID, Old Medicaid card

* + Marriage Certificate Record, Consulate Card.
	+ **Proof of New York Residency-**

 Utility bill, recent mail addressed to you with post office mark, hospital bill, bank statement

* + **Proof of Income-**
	+ **Pay Stubs-**8 if paid weekly/ 4 if paid bi-weekly (every two weeks), WRITTEN Statement from Employer and/or written statement from patient (signed, dated)
	+ **If Unemployed-**receiving Unemployment Benefits-copy of payments
	+ **SS Award Letter, and Pension**
	+ **If Patient not working a** Notarized letter stating not working and a letter from person supporting them.
	+ **Letter of support-**from the person providing room and board.

Documentos necesarios para poder procesar su aplicacion de Medicaid o Asistencia Financiera.

**Estamos en la oficina (G69A)** de Lunes a Viernes de 8:30am hasta las 5:30pm.

* **Identificacion-**Certificado de Nacimiento, Pasaporte, licencia de conducer, Certificado de Matrimonio Tarjeta de Medicaid, Tarjeta de Seguro social, Cedula de su Pais.
* **La prueba de la Ciudadania o de su posicion Extranjera**
* **La prueba de direccion-**Factura de utilidades, Carta enviada por correo en su nombre.(sobre)
* **Recibos de ingreso-**8talonarios si su pago es semanal, 4 talonarios sis u pago es cada dos semanas
* **U**na carta de Notarizada del paciente avisando- no esta trabajando, y una carta de la persona otorgando ayuda.l Centro de Hospitalidad de 1546 Castleton Avenue.
* **La Carta De Apoyo/con direccion del domicilio.**

Please call **718-818-2290/4572/2361/2289** for an appointment. Please make certain your documents are brought in ASAP.

Por Favor llame al **718-818-2290/4572/2361/2289** para una cita. Por Favor asegurese de traer los documentos lo mas pronto possible.

**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



|  |
| --- |
| 355 Bard Avenue, Staten Island, New York 10310 |
| **Denial Letter – Exhibit 5** |

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Clinic Visits Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Richmond University Medical Center has reviewed your application for Financial Assistance. Based on the information you provided the hospital has determined that you are not eligible for assistance.

Richmond Universita Medical Centré ha revisado su solicitud de asistencia financiera. Sobre la base de la información que usted proporciona, el hospital ha determinado que es elegible para recibir asistencia.

Les Richmond Université Medical Centre ont étudié votre demande d’aide financière. Sur la base des informations dont vous disposez, I’hôpital a décide que vos estes en droit de bénéficier d’une aide.

Richmond University Medical Center ha esaminato la Sua domanda di assistenza finanziaria. Alla luce delle informazioni da Lei Forniteci, l’ospedate ha deciso che Lei e idoneo/a al percepimento di detta assistenza.

**For further inquiries, you can contact the Department of Health at 1-800-804-5447 or**

**1-518-402-6993.**

**Para más consultas, puede contactar al Departamento de Salud al 1-800-804-5447 o al 1-518-402-6993.**

Date of Determination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initiated by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Financial Counselor

Date Applicant was notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed/Denied by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Director Patient Access/Clinics



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| --- |
| 355 Bard Avenue, Staten Island, New York 10310 |
| **Approval Letter - Exhibit 6** |

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Clinic Visits Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

Richmond Universita Medical Centré ha revisado su solicitud de asistencia financiera. Sobre la base de la información que usted proporciona, el hospital ha determinado que es elegible para recibir asistencia.

Les Richmond Université Medical Centre ont étudié votre demande d’aide financière. Sur la base des informations dont vous disposez, I ’hôpital a décidé que vos estes en droit de bénéficier d’une aide.

Richmond University Medical Center ha esaminato la Sua domanda di assistenza finanziaria. Alla luce delle informazioni da Lei Forniteci, l’ospedate ha deciso che Lei e idoneo/a al percepimento di detta assistenza.

Date of Determination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initiated by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Financial Counselor

Date Applicant was notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed/Approved by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Director Patient Access/Clinics