Are you uninsured?

A helpful resource for patients in need of financial assistance

Financial Assistance Policy and Application

Bassett Healthcare Network
Cobleskill Regional Hospital

2020

Bassett Healthcare Network
Cobleskill Regional Hospital

178 Grandview Drive
Cobleskill, NY 12043
(518) 254-3456
www.bassett.org

Cobleskill Regional Hospital
Financial Assistance Policy and Application

January 2020

Cobleskill Regional Hospital's Financial Assistance Policy provides free care to uninsured 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 ability 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. 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 (518) 254-3381, 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 and Elective Surgery
- Any date of service more than two hundred forty (240) days prior to the mailing of the first post-discharge statement
- Co-payments, co-insurance, and deductible balances

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.
- You may be required to apply for Medicaid after submission of an application, unless your family income exceeds Medicaid guidelines. Additionally, you must apply for all public health insurance programs for which you are eligible, including Child Health Plus, before approval for financial assistance. If you already have a Medicaid denial, it must be less than six months old.
- Your family's annual, gross household income does not exceed the following federal poverty limits (FPL):

Family Size	Income Level (FPL)	FPL x 200%	FPL x 300%*
1	$12,760	$25,520	$38,280
2	$17,240	$34,480	$51,720
3	$21,720	$43,440	$65,160
4	$26,200	$52,400	$78,600
5	$30,680	$61,360	$92,040
6	$35,160	$70,320	$105,480
7	$39,640	$79,280	$118,920
8	$44,120	$88,240	$132,360
Each Additional:	$4,480	$8,960	$13,440
Discount %	100%	100%	100%

***Any 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.**

Note: 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 or modify 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.
- If your family income is below Medicaid guidelines, you will be required to submit an application for Medicaid before your application for financial assistance is approved.
- Applications for financial assistance will not be approved if Medicaid is denied based on your failure to complete an application, or if you refuse to comply with any conditions of eligibility. Applications for financial assistance may also be denied if applicants fail to carry employer-sponsored health insurance, or apply for other public programs for which you may be eligible.

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

Cobleskill Regional Hospital will send you a letter 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, but only to the extent of the amount of your financial assistance award.

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:

Cobleskill Regional Hospital
Attention: FAP Appeals Dept. / Administration
178 Grandview Drive
Cobleskill, NY 12043

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 Cobleskill Regional Hospital Account Representatives at (607)-547-3480 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:

Cobleskill Regional Hospital
Business Office—Financial Assistance Program
178 Grandview Drive
Cobleskill, NY 12043

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, Medical Self Pay Accounts Receivable Services, LLC (MedSPAR). 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.

At least thirty (30) days after mailing the final MedSPAR statement with notice as required by the Patient Protection and Affordable Care Act, an unpaid balance not subject to an approved installment payment arrangement or eligible for financial assistance may be referred to third party collection. Once referred to third party collection, depending on factors including the amount due and the responsible party's personal circumstances, the outstanding balance may be subject to one or more of the following: credit reporting, litigation which may result in a judgment lien on real and/or personal property and judgment enforcement. If an outstanding balance is in third party collection, financial assistance applications will be accepted if received within 240 days of the mailing of the first MedSPAR statement referenced above. Patients or responsible parties ineligible for financial assistance will be offered the opportunity to voluntary resolve their outstanding balances with our third party agency/law firm.

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 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 will pursue any pending application for assistance or third-party coverage (Medicaid, Medicare, Insurance, etc.) that may be available for payment of these hospital and/or physician charges. I will take any action reasonably necessary to obtain such assistance, and will assign and pay over to the hospital any proceeds (but only to the extent of my hospital and/or physician charges) paid by any third-party coverage, regardless of when any such payment is received. 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.

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. However, any such lien is only to the extent of these charges, or any such recovery, whichever is less.

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 (f:\forms\bhsc\.pub)