Bacharach Institute for Rehabilitation
Financial Assistance Policy – Plain Language Summary ("PLS")

Bacharach Institute for Rehabilitation ("BIR") Financial Assistance Policy ("FAP") exists to provide eligible patients with partially or fully-discounted medically necessary healthcare services. Patients seeking financial assistance must apply for the programs offered. The following is a summary of the policy:

Eligible Services - Medically necessary healthcare services provided and billed by BIR. The FAP only applies to services billed by BIR. Related services separately billed by other providers, such as independent consulting physicians, may not be covered under the FAP.

Eligible Patients - Patients receiving eligible services who submit a completed financial assistance application ("Application") (including related documentation/information) and who are determined eligible for financial assistance by BIR.

How to Apply – The FAP and related Application may be obtained/completed/submitted as follows:

- By visiting BIR's website at www.bacharach.org;
- Requesting documents by mail by calling BIR's Business Office at (609) 748-5454;
- By visiting the Admissions Office in person located at 61 West Jimmie Leeds Road, Pomona NJ 08240, between the hours of 8:30 AM and 4:30 PM.
- Mail completed Applications (with all documentation/information) specified to:

Bacharach Institute for Rehabilitation
61 West Jimmie Leeds Road
Pomona, New Jersey 08240
Attention: Business Office

Determination of Financial Assistance Eligibility - Generally, uninsured patients are eligible for financial assistance. Additionally, underinsured patients may be eligible, using a sliding scale, when their family gross income is at or below 200% of FPG. Eligibility for financial assistance means that eligible patients will have their care fully or partially discounted and will not be billed more than "Amounts Generally Billed" ("AGB") to insured persons (AGB, as defined in IRC §501(r) by the Internal Revenue Service). Financial assistance levels, based solely on family gross income and FPG, are:

- Underinsured individuals with family gross income at 0 to 100% of FPG;
  Full financial assistance; $0 is billable to the patient.
- Underinsured individuals with family gross income greater than 100% but less than or equal to 200% of FPG;
  Partial financial assistance; AGB is maximum billable to the patient.
- All uninsured individuals;
  Partial financial assistance; AGB is maximum billable to the patient.

Note: Other criteria beyond FPG may also be considered (i.e., residency, State program denials), which may result in exceptions to the preceding. If no family gross income is reported, information will be required as to how daily needs are met.

BIR's Business Office Manager or another designee will review submitted applications and determines financial assistance eligibility in accordance with BIR's FAP. If an incomplete application is received, the applicant will be notified and given an opportunity to furnish the required missing documentation/information.

BIR translates its FAP, Applications and PLS in other languages wherein the primary language of BIR's primary service area represents the lesser of 5% or 1,000 individuals.

For help, assistance or questions please call BIR's Business Office at (609) 748-5454 or visit the Admissions Office located at 61 West Jimmie Leeds Road, Pomona NJ 08240, between the hours of 8:30 AM and 4:30 PM.

Bacharach Institute for Rehabilitation **Title:** Financial Assistance Policy ("FAP") **Approved By:** *Jeanne Vuksta*	**Original:** 04/87 **Reviewed:** 04/88, 04/89, 04/90, 04/91, 10/92, 09/93, 05/02, 05/05 **Revised:** 04/90, 09/94, 06/99, 08/07, 05/12, 1/16, 5/16, 5/17, 5/18, 8/19, 08/20	**Policy#** 12.2.3 **KF:** **Page 1 of 5**

Purpose:

Bacharach Institute for Rehabilitation ("BIR") offers medically necessary healthcare services which allow patients to restore their independence and well-being. BIR strives to ensure that all patients receive the medically necessary care they require regardless of ability to pay and offers financial assistance in order to provide additional sources of coverage for patients who are uninsured, underinsured and cannot afford to pay.

Policy:

This policy is written by the Business Office Manager. It is reviewed by the Chief Financial Officer and the Hospital Administrator/CEO. This policy is distributed to Administration, Admissions, and the Business Office.

Financial assistance is only available for medically necessary healthcare services. Not all services provided within BIR's hospital facility are covered under this FAP. Please refer to Appendix A for a list of providers that provide medically necessary healthcare services within BIR's hospital facility. This appendix specifies which providers are covered under this FAP and which are not. The provider listing will be reviewed quarterly and updated; if necessary.

Financial Assistance & Eligibility Criteria:

BIR provides Uncompensated Care through its Administrative Charity Fund to individuals who cannot afford to pay for all or part of the hospital services provided. The Administrative Charity Fund is a BIR program in which free or discounted care is available to patients who receive medically necessary healthcare services within the hospital facility. Financial assistance will be awarded on a first request, first served basis to eligible patients until BIR's annual compliance level is met. The annual compliance level will be determined yearly.

Patients may be eligible for financial assistance through the Administrative Charity Fund if they meet the following criteria:

I. Healthcare Services Criteria;
II. Residency Criteria; and
III. Income Criteria.

Healthcare Services Criteria: The use of the Administrative Charity Fund is limited to Inpatient and electromyography ("EMG") services.

Residency Criteria: In order to be eligible patients must be Atlantic and Cape May County (New Jersey) residents, Undocumented Aliens, or Migrants living in New Jersey while receiving care.

Income Criteria: Patients with family gross income less than or equal to 100% of Federal Poverty Guidelines ("FPG") are eligible for 100% Administrative Charity Fund assistance. Patients with family gross income greater than 100% but less than 200% of FPG are eligible for discounted care. Please refer to Appendix B to view the FPG sliding fee scale used to determine discounts available and patient responsibility.

Eligibility is conditional upon the fact that reasonable action is taken to secure "other coverage" such as Medicaid, Supplemental Security Income, Social Security Disability, etc. Failure to do so will result in financial assistance being denied.
Additionally BIR adheres to the rules set forth in Public Law 2008, Chapter 60, New Jersey Uninsured Discount, wherein all uninsured patients with family gross income less than 500% of FPG will be eligible for discounted care under this program. Under this program an eligible patient will be charged an amount no greater than 115% of the applicable payment rate under the Federal Medicare program for the healthcare services rendered.

Method for Applying:

Patients who believe they satisfy the eligibility criteria must submit a completed Request for Determination of Eligibility for the Subsidized Funding Program ("Application") to receive a discount under the Administrative Charity Fund.

Applications are available on the BIR website (www.bacharach.org) or may be requested by calling the BIR Business Office at (609) 748-5454. Paper copies of the Application are also available at the Admissions Office located at:

Bacharach Institute for Rehabilitation
61 West Jimmie Leeds Road
Pomona, New Jersey 08240

The hours of operation are Monday – Friday 8:30 am to 4:30 pm.

Patients have 240 days from the date of the first post-discharge billing statement to submit a completed Application for financial assistance. BIR, at its discretion, may accept applications after 240 days.

An Application will not be considered complete if it does not include the documents required for submission. Applicants will have to provide proof of income which includes: pay stubs, letter from your accountant verifying net income, if self-employed, copy of bank statement, if electronically deposited, and if there is no other proof, a tax return can be submitted. Additionally, please provide your Social Security Denial Letter and/or Welfare Denial Letter. The highest income amounts will be used to determine eligibility.

Completed Applications (with required documentation) should be mailed to:

Bacharach Institute for Rehabilitation
61 West Jimmie Leeds Road
Pomona, New Jersey 08240
Attention: Business Office

Procedures:

The Business Office Manager or a designee will determine eligibility based on the Application (and required documentation) submitted by the patient. If the eligibility criteria are satisfied then the Business Office Manager will petition the Administrator/CEO for use of the fund. The Administrator/CEO has the authority to override the determination.

If the applicant is approved, the approval will be conditional upon the fact that reasonable action on the applicant's part was taken to secure other coverage as described above. If applicant fails to do so, approval will be denied.

The FAP-eligibility determination will be communicated to the patient in writing within five (5) working days.

If an incomplete application is received, BIR will provide the patient with a plain language summary of the FAP ("PLS"). The PLS is a written statement that notifies an individual that the hospital facility offers financial assistance and provides additional information regarding this FAP in language that is clear, concise, and easy to understand. BIR will also provide the patient with written notice which describes the additional information/documentation needed to make a FAP-eligibility determination and give the patient a reasonable amount of time (30 days) to provide the requested documentation. Additionally, BIR, and any third parties acting on their behalf, will suspend any

extraordinary collection actions (“ECAs”) (discussed later in this FAP) to obtain payment during this time period.

Once a patient submits a completed Application, BIR, or any third parties acting on their behalf, will suspend any ECAs undertaken against the individual. They will also make and document a FAP-eligibility determination in a timely manner; and notify the responsible party or individual in writing of the determination and basis for determination.
If a patient is deemed FAP-eligible BIR will provide an updated billing statement indicating the amount the FAP-eligible individual owes, how that amount was determined and how information pertaining to Amount Generally Billed (“AGB”), as further discussed below, may be obtained, refund any excess payments made by the individual; and work with third parties to take all reasonable available measures to reverse any ECAs previously undertaken against the patient to collect the debt.

Basis for Calculating Amounts Charged to Patients:

Pursuant to Internal Revenue Code §501(r)(5), in the case of medically necessary care, FAP-eligible patients will not be charged more than an individual who has insurance covering such care.

All patients eligible for assistance under this FAP may be eligible for this discount. This includes all uninsured patients and underinsured patients whose family gross income is greater than 100% but less than 200% of FPG.

BIR has adopted the Look-Back Method to calculate its AGB percentage. This AGB percentage is calculated annually based on all claims allowed by Medicare-Fee-for-Service + Private Health Insurers over a 12 month period, divided by the gross charges associated with these claims. The applicable AGB % will be applied to gross charges to determine the AGB.

Additional information pertaining to the AGB percentage and how that percentage was calculated is available upon request and free of charge.

Any individual determined to be FAP-eligible will not be charged more than AGB for medically necessary healthcare services pursuant to Internal Revenue Code §501(r)(5). In addition, any FAP-eligible individual will always be charged the lesser of AGB or any discounted rate available under this FAP.

Widely Publicizing FAP, Application & PLS:

BIR’s FAP, Application and PLS are available in English and in the primary language of populations with limited proficiency in English (“LEP”) that constitute the lesser of 1,000 individuals or 5% of BIR’s primary service area.

The FAP, Application and PLS are all posted on BIR’s website (www.bacharach.org) and are available free of charge, upon request. You may request any of these documents by calling (609) 748-5454. Additionally, paper copies are also available in various areas throughout the hospital facility, which include the Admissions and Business Offices.

Signs or displays, to inform our patients about the availability of financial assistance, are posted in admitting/registration departments.

All patients will be offered a copy of the PLS as part of the intake process.

Patients will be notified about the availability of financial assistance through the BIR billing statements. Each billing statement includes conspicuous written notice which informs the recipient about the availability of financial assistance. The statement also includes the website where an individual can obtain copies of the FAP, Application and PLS. Additionally, it includes the telephone number that patients can call if they have questions regarding the availability of financial assistance and the application process.

Billing Process:

Inpatient – Bills are dropped every day approximately ten (10) days after discharge.

Outpatient – Bills are dropped on the 1st and the 15th of every month and at discharge.

Certain bills are on a thirty (30) day cycle and only drop on the 1st of the month. Others are on a fifteen (15) day cycle and drop on the 1st and the 15th of the month. The financial class will determine this.

Rebills and Secondary – Bills are dropped every day.

All UB04 and 1500's are downloaded into the E-Premis System.

Inpatient claims are edited and submitted the same day. All other claims are edited and submitted within three (3) days. Problem and claims missing diagnosis are updated daily until all claims are submitted.

Claims are transmitted daily.

Payments are auto posted through electronic remittances and Co-Pay batches. All other payments are manually posted. The daily payments are separated by insurance company and reported to each Representative according to their assigned Financial Class and Patient Type.

The Representative will check for any denials and update the credit notes by indicating what procedure is taken.

Credit Notes are used to explain the status of the account and document any work performed during this review. There is an action date that is used to follow up on the account on the date keyed. If an action date is keyed in, the note will appear in the biller's work Queue according to their assigned Financial Class and Patient Type.

Collection Process:

Outpatient accounts are manually discharged after sixty (60) days of no charge activity. There are certain circumstances that warrant an outpatient account not to be discharged. These accounts are coded as permanent repeating outpatient.

All discharged accounts are aged and once coded as a Private Pay account, meaning the balance is due from the Patient, then put in the mailer cycle. Mailers are printed by an outside agency (MedHost) on or about the 15th of every month. Unless manually changed, the mailers will age and after approximately 3 mailers, the patient account will be reviewed to be considered a Bad Debt account.

When an account becomes a status Bad Debt, a collection letter is sent to the guarantor advising them if the balance is not paid within 30 days, it will be sent to an outside collection agency. After 30 days if the balance is not paid, another letter is sent to the guarantor advising them the account is now placed with an outside collection agency.

Accounts are alphabetically split between two collection agencies. They each have six (6) months to collect. If there is no activity in six months, it is then discontinued and placed with the other collection agency. If there is no activity for six months after the second placement, it is written-off. Each account is coded with the agency name, date and amount at the time of placement so it can easily be determined at what point the account is at any time.

Write-Off Procedure:

Follow-up staff will review assigned accounts in conjunction with their job responsibilities and identify account transactions potentially eligible for write-off. Other Business Office staff may identify account transactions potentially eligible for write-off as part of their job responsibilities. Account transactions that meet write-off criteria may include accounts with billing errors that result in non-payment from a third party that cannot be billed to the patient, pre-existing conditions, or an invalid service.

Staff will collect all data and supporting documentation relative to the write-off request.

Staff will prepare the Uncollected Accounts Write-Off Request with a detailed explanation regarding the circumstances surrounding the write-off and the Asst Business Office Manager will assign the appropriate Write-Off code and forward it to the Business Office Manager.

The Business Office Manager will review the write-off request and sign approval or denial based on the following guidelines:

Employee	Approval Limits
Business Office Manager	maximum of $5,000
Chief Financial Officer	$5,000 - $25,000
Administrator/CEO	$25,001+

Compliance with Internal Revenue Code §501(r)(6):

BIR does not engage in any ECAs as defined by Internal Revenue Code §501(r)(6) prior to the expiration of the "Notification Period". The Notification Period is defined as a 120-day period, which begins on the date of the 1st post-discharge billing statement, in which no ECAs may be initiated against the patient.

Subsequent to the Notification Period BIR, or any third parties acting on their behalf, may initiate the following ECAs against a patient for an unpaid balance if a FAP-eligibility determination has not been made or if an individual is ineligible for financial assistance.

1. Referral to a collection agency;
2. Deferring, denying or requiring payment before providing medically necessary care because of an individual's nonpayment for previously provided care; and
3. Commencing a civil action against an individual.

BIR may authorize third parties to initiate ECAs on delinquent patient accounts after the Notification Period. BIR will ensure reasonable efforts have been taken to determine whether an individual is eligible for financial assistance under this FAP. BIR will take the following actions at least 30 days prior to initiating any ECA:

1. The patient has been provided with written notice which:

    a. Indicates that financial assistance is available for eligible patients;
    b. Identifies the ECA(s) that BIR intends to initiate to obtain payment for the care; and
    c. States a deadline after which such ECAs may be initiated.

2. The patient has received a copy of the PLS with this written notification; and

3. Reasonable efforts have been made to orally notify the individual about the FAP and how the individual may obtain assistance with the financial assistance application process.

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Appendix A – Provider Listing:

The following services provided to Bacharach Institute for Rehabilitation patients by outside providers are not covered under BIR's Financial Assistance Policy:

Physician's consulting on Non-Rehabilitative Services
Lab and Radiology testing
Dialysis services
Ambulance/Transport services
Prosthetic and Orthotic services

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Appendix B – Sliding Fee Scale:

Bacharach Institute for Rehabilitation, Inc.

Subject/Title:	Department	Policy #	LD	
Administrator's	Fiscal Services	Bus. Office	1.1.8	Aug-20
Subsidized Care Fund				

FAMILY SIZE:								PATIENT PAYS:
1	2	3	4	5	6	7	8	
$12,760	$17,240	$21,720	$26,200	$30,680	$35,160	$39,640	$44,120	0%
$14,036	$18,964	$23,892	$28,820	$33,748	$38,676	$43,604	$48,532	10%
$15,312	$20,688	$26,064	$31,440	$36,816	$42,192	$47,568	$52,944	20%
$16,588	$22,412	$28,236	$34,060	$39,884	$45,708	$51,532	$57,356	30%
$17,864	$24,136	$30,408	$36,680	$42,952	$49,224	$55,496	$61,768	40%
$19,140	$25,860	$32,580	$39,300	$46,020	$52,740	$59,460	$66,180	50%
$20,416	$27,584	$34,752	$41,920	$49,088	$56,256	$63,424	$70,592	60%
$21,692	$29,308	$36,924	$44,540	$52,156	$59,772	$67,388	$75,004	70%
$22,968	$31,032	$39,096	$47,160	$55,224	$63,288	$71,352	$79,416	80%
$24,244	$32,756	$41,268	$49,780	$58,292	$66,804	$75,316	$83,828	90%
$25,520	$34,480	$43,440	$52,400	$61,360	$70,320	$79,280	$88,240	100%

Jeanne Vuksta

Authorized by: _____ Date Formulated: 06/88 Reviewed: 04/93

6/89,3/90,4/90,4/91,7/92,4/93

Revised: 05/15

4/94,5/95, 5/96, 4/97, 6/99, 8/07, 5/12, 3/13, 3/14, 5/15, 5/16,5/17,5/18, 8/19, 8/20

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR THE SUBSIDIZED FUNDING PROGRAM

ENCLOSE PROOF OF INCOME FOR THE LAST 3 AND 12 MONTHS.

BACHARACH INSTITUTE FOR REHABILITATION
PROMONA, NEW JERSEY 08240

DATE OF REQUEST: _____

I hereby request that Bacharach Institute for Rehabilitation make a written determination of my eligibility for the Subsidized Funding Program at Bacharach Institute for Rehabilitation. I understand that the information which I submit concerning my annual income and family size is subject to verification by Bacharach Hospital. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services through the Subsidized Funding Program, and that I will be liable for the charges for services provided.

1. NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____
NUMBER AND STREET CITY STATE ZIP CODE

TELEPHONE # ( ) _____

BIRTH DATE: _____ SOCIAL SECURITY # _____

2. OCCUPATION: _____ EMPLOYER: _____

MEDICARE #: _____ MEDICAID #: _____

OTHER INSURANCE: _____ INSURANCE I.D. # _____

3. **INCOME: List income for applicant and anyone residing in same household with applicant:**

	TOTAL FOR LAST 3 MONTHS	TOTAL FOR LAST 12 MONTHS
WAGES.....		
FARM OR SELF-EMPLOYED.....		
PUBLIC ASSISTANCE.....		
DISABILITY.....		
SOCIAL SECURITY.....		
UNEMPLOYMENT COMPENSATION.....		
STRIKE BENEFITS.....		
ALIMONY.....		
CHILD SUPPORT.....		
MILITARY FAMILY ALLOTMENTS.....		
PENSIONS.....		
DIVIDENDS, INTEREST, RENT.....		

4. FAMILY SIZE: NAMES OF PERSONS RESIDING IN SAME HOUSEHOLD WITH APPLICANT:

NAME	RELATIONSHIP	AGE

5. Type of Service: Inpatient ( ) Outpatient ( ) Service:_____

I have applied for: (circle one) SSI SSD MEDICAID/TYPE:_____

Date Applied: _____ Name of Case Worker: _____

I affirm that the above information is true and correct to the best of my knowledge.

_____ _____

DATE SIGNATURE