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Owner	Courtney Pittman: Director of Patient Access Services
Area	Revenue Cycle
Applicability	Erie County Medical Center
References	REV-006

Charity Care/Financial Assistance Program (FAP)

I. Policy Purpose, Statement of Policy, and Policy Goals:

The Erie County Medical Center Corporation ("ECMCC") is dedicated to being a medical center of choice through excellence in patient care and customer service. ECMCC honors its mission to serve patients regardless of their ability to pay through a Charity Care/Financial Assistance Program (referred to as the Program). The Program is designed to assist low income patients who have no health insurance, patients who have exhausted their insurance coverage, or low income patients who demonstrate an inability to pay co-pays and deductibles for rendered medical services. A patient who is unable to pay hospital bill(s) is encouraged to apply for financial assistance by completing a Program application. The purpose of this policy and procedure is to ensure that approval of discounts for health care services rendered is consistent, fair and in compliance with all Federal and New York State laws regarding financial assistance for health care services.

Administration of this policy is the responsibility of Financial Counseling Services.

All allowances applied under this policy are part of ECMCC's overall Program and are considered charity care discounts.

II. Procedure

a. Eligibility:

Levels of financial assistance will be awarded based upon household income in accordance with the Federal Poverty Guidelines as published annually by the Department of Health and Human Services and, when necessary, asset verification.

Patients will be directed to contact Financial Counseling Services to initiate the application process. Patients will complete the application either in writing or verbally over the telephone with the financial counselor and provide necessary documentation to financial counseling services. Hospital staff dealing with registration, billing and collections will be trained on the guidelines for referral to Financial Counseling.

A patient may apply for financial assistance at any point, starting from the date of service and throughout the collections process. All patients who are uninsured and under

a. It is the responsibility of the patient to actively participate in ECMCC's Program screening process and to provide requested information on a timely basis; Including providing ECMCC with information concerning actual or potential available health benefits coverage, financial status, (i.e. income) and any other information that is necessary for ECMCC to make a determination regarding the patient's financial and insured status. ECMCC Financial Counseling Department screens uninsured and underinsured patients within 30 days of the initial date of service. In certain situations, ECMCC may be able to presume patient eligibility to receive Program assistance even though an application has not been completed. This will typically occur when a financial counselor, on the basis of available information, determines that the patient's household income, based on family size, falls within one of ECMCC's Program award levels. Available information for determining presumptive eligibility includes, but is not limited to, information from a partially completed Program application, information in a patient's credit notes based on previous visits and collection efforts, information collection analytics data. If a presumptive eligible patient is subsequently determined to be ineligible for the Program, the financial assistance award will be reversed.

A patient may be requested by a Financial Counselor to enroll in a government-funded program. Compliance with the application and approval process is preferred.

If approved, financial assistance shall be awarded on the technical component charges for all emergent and medically necessary inpatient, outpatient, and emergency room services rendered at ECMCC.

If denied, applicants have the right to appeal a decision. Appeals must be submitted in writing.

A patient is required to re-apply every twelve months if on fixed unearned income Social Security Retirement, Supplemental Security Income, Social Security Disability, Social Security Survivors Benefits and pension. Patient must reapply every six months if income is earned.

If religious beliefs prohibit the application of assistance to State or County funded agencies, the Program will be offered and application accepted for approval or denial. Application

process remains the same and documentation requirements will not be waived.

The Program does not cover prescriptions, Level 2 dental procedures (dentures, partials, root canals, implants, etc.), private physician charges (radiologist, anesthesiologist, etc.), and elective non-medically necessary procedures, non-emergent services as determined by clinician, private room differentials, telephone/television charges, or services received at Terrace View Long Term Care Facility.

ECMCC recognizes that low-income Medicare beneficiaries and those under-insured may be unable to meet their deductible and coinsurance obligations. Medicare beneficiaries and those under-insured are eligible for the Program but follow the same Program policy and procedures to determine financial need. Financial need for Medicare beneficiaries will be determined using the same guidelines used for non-Medicare beneficiaries.

Non-US citizens may be eligible for the Program as long as they provide identification and proof of income. The information can be provided in the currency of their home country, but eligibility will be based on the US conversion of those funds. A financial counselor may contact the patient to apply for government funded programs if the patient receives emergency services.

b. Program Levels: Attachment A (Income Guidelines)

ECMCC offers three coverage levels for eligible patients.

- Level 1 – Household Income 200% or less of Federal Poverty Guideline
- Level 2 – Household Income 300% or less of Federal Poverty Guideline
- Level 3 – Household Income 400% or less of Federal Poverty Guideline

c. Program Award Guidelines
Amounts Generally Billed (AGB):

- Patients qualifying for financial assistance under this Program receiving emergency or other medically necessary services will not be charged more than the amount generally billed (AGB) to individuals who have insurance covering such care. ECMC will utilize the prospective method based on the Medicaid fee-for-service schedule to determine the AGB discount provided.
- Qualifying patients will receive the AGB discount on gross charges prior to other financial assistance discount.

d. Level 1:
Patients qualifying under Level 1 may receive up to a 100% discount for inpatient and outpatient covered services. Payment of non-covered services is due at the time of service unless a repayment arrangement has been agreed to by the service location or ECMCC's In-House Collection Department.

Level 2:

Patients qualifying under Level 2 may receive up to a 90% discount for both inpatient and outpatient services covered under this program.

For services covered under Level 2 there is a 10% patient cost share due at the time of service unless a repayment arrangement has otherwise been agreed to by ECMCC's In-House Collection Department.

Payment of non-covered services is due at the time of service unless a repayment arrangement has been agreed to by the service location or ECMCC's In-House Collection Department.

Level 3:

Patients qualifying under Level 3 may receive up to a 80% discount for both inpatient and outpatient services covered under this program.

For services covered under Level 3 there is a 20% patient cost share due at the time of service unless a repayment arrangement has otherwise been agreed to by ECMCC's In-House Collection Department.

Payment of non-covered services is due at the time of service unless a repayment arrangement has been agreed to by the service location or ECMCC's In-House Collection Department.

e. Application Processing Guidelines:

A financial counselor will interview the patient either in person or via telephone and determine eligibility for the Program by comparing the total household income from the pay stubs/ statement provided, the number of dependents listed on the application and if applicable, resources available.

Determinations regarding eligibility for the Program will be provided to the patient within 30 days of receipt of all application documentation.

Gross income figures will be used to calculate unless self–employed. If self-employed, net income will be used from 3–month ledger or other document provided. This mirrors the calculation methods used by LDSS (Local Department of Social Services).

1. If the patient indicates they have health insurance coverage or treatment was related to an accident or injury, the account history will be reviewed to determine if this information was previously provided and subsequent bill generated. If not, the eligibility of the health insurance coverage will be verified. If valid, the patient accounting system will be updated and billed to the appropriate payer. The patient shall be notified that ECMCC is conditionally approving their request until a disposition from the health insurance carrier is received.
2. If the patient is seeking dental services only and does not have dental insurance and meets the eligibility requirements under the ECMCC Financial Assistance Program the patient well be approved as Dental Financial Assistance Program only.
3. If the patient expires prior to receipt of application and consent for treatment, the hospital will send at least two statements. If no payment arrangement has been made within 30 days of the last statement and the combined patient responsibility is over $1,000 dollars or more, the accounts will be placed in bad debt and assigned to

legal for estate review. If after review no estate is found with all efforts exhausted, the balance will be adjusted off as deceased-no estate found. If only partial payment is received, the remaining balance will be adjusted off as deceased-no estate found.

4. If the combined patient responsibility is less than $1000 dollars, the balance will be adjusted off as deceased-no estate found.
5. If the patient expires after receipt of the application, the estate is notified of the decision. Determination is sent to address listed on the application with a detailed explanation of what the patient owes and a notice of claim for the balance is filed with surrogates' court having oversight on the estate.
6. A budget sheet that determines eligibility for Medicaid generated by an ECMCC financial counselor may be submitted as acceptable charity care/financial assistance application documentation.
7. If a Medicaid or Medicaid Managed client has limited coverage, charity care/ financial assistance will be applied to balances. Medicaid or Medicaid Managed recipients who receive an Admission Denial notice or notice of ALC; all Self Pay balances will be adjusted to zero by the Supervisor of Financial Counseling. This is considered a Medicaid hardship and requires no application or supporting documentation.
8. If unable to complete a Medicaid application or charity care/financial assistance application and a patient has been confirmed as homeless, all self pay balances will be adjusted to zero by the Supervisor of Financial Counseling. This will be considered a hardship adjustment and requires no application or supporting documentation.
9. ECMCC will not permit collections from a patient who has been determined as eligible for Medicaid at the time services were received and for which Medicaid payment is available. This is provided that patient has completed the Medicaid application in connection with such services. ECMCC will not send a bill to a collection agency while a completed Financial Assistance application is in pending approval status.
10. Once it has been determined that the patient's income falls within the eligible range for financial assistance, and it has been verified that patient account balances are in good standing, an approval letter will be generated and provided to the patient.
11. Requests for consideration for a discount on medically necessary services that do not meet the standard Financial Assistance policy will be reviewed on a case-by-case basis. This will be referred to as a hardship. The Financial Assistance application and supporting documentation will be reviewed by the Financial Counseling Supervisor. Applicants will receive a decision in writing within 30 days of review. Any hardship requests that do not meet these criteria may be reviewed by ECMCC Corporate Compliance, Vice President of Revenue Cycle and/or The ECMCC Board of Directors.
12. Records of both approvals and denials will be maintained by the financial counseling office. In addition, all paperwork submitted shall be retained for a period of 6 years.
13. Once approved, a patient must present their letter of approval at the time of registration for future services. The registration staff will review to ensure that the

approval has not expired. Accounts will be rated to reflect charity care/financial assistance for the discount using the following codes:
FAP2
FAP3
FAP4

14. If a patient is only approved for Dental Financial Assistance, a patient must present their letter of approval at the time of registration for future services. The registration staff will review to ensure that the approval has not expired. Dental accounts will be rated to reflect charity care/financial assistance for the discount using one of the following codes:
DFAP2
DFAP3
DFAP4
15. Financial Counselors will review the application for completeness. The following items must accompany the application:
    - Two (2) weeks of recent pay stubs, unemployment checks or other verifiable proof of income from any other source including disability, pension, etc. for all family members living in the household. Family members include: spouse, parent (if the applicant is 18-20 years of age), child and any individual who has been legally designated as a household member.
16. If unable to verify income, a denial for assistance will be generated unless the patient signs a notarized/commissioner of deeds witnessed self-attestation of income.
17. Approval for unearned income patients expires after 12 months. Approval for all other earned income patients expires after 6 months. Patient must present letter of approval for each service within that time frame.
18. When approval expires, the patient is required to reapply by submitting a new completed application & documents.
19. Charity care/financial assistance applicants have the right to appeal the decision to deny financial assistance awards.
20. The appeal procedure is as follows:
    - The applicant must send a written grievance to ECMCC- FAP (Financial Assistance Program) Department within 20 days of the date of the denial letter. New information should be sent if possible to support the appeal.
    - The appeal committee: Financial Counseling Supervisor, Manager of Patient Access Services and Vice President of Revenue Cycle will review cases for appeal on a bi-weekly basis.
    - The appeal determination will be answered in writing by the appeals committee within 30 days. The answer will include the department decision and a brief explanation of the reason(s) for the action.
21. Uninsured patients who are ineligible for a government program or our charity care/financial assistance program are still offered our self-pay rate. The financial

counselor will provide patients a cost estimate for services, a self-pay quote and requested down payment agreement.

22. ECMCC offers installment plans for eligible patients. Installment plans are non-interest bearing and will not be accelerated for a missed payment.
23. Payments made on any medically necessary services covered under the Program made prior to the approval of assistance are non-refundable.

Reference:

- PHL Section 2807k Subdivision 9A
- 2026 Federal Poverty Level Guidelines

ECMCC has developed these policies and procedures in conjunction with administrative and clinical departments. These documents were designed to aid the qualified health care team in making clinical decisions about patient care. These policies and procedures should not be construed as dictating exclusive courses of treatment and/or procedures. No health care team member should view these documents and their bibliographic references as a final authority on patient care. Variations from these policies and procedures may be warranted in actual practice based upon individual patient characteristics and clinical judgment in unique care circumstances.

Approval Signatures

Step Description	Approver	Date
	Andrew Davis: President & Chief Operating Officer	06/2026
	Nicolette Wilson: Vice President of Revenue Cycle	06/2026
	Courtney Pittman: Director of Patient Access Services	06/2026

Applicability

Erie County Medical Center