

SUBJECT: FINANCIAL AID POLICY	NUMBER:	
OWNER: OFFICE OF THE PRESIDENT		
EFFECTIVE DATE: 11/2013	REVISED DATE: 04/26	SUPERSEDES: 2/20, 4/20, 2/22, 4/22, 4/23, 4/24, 1/25, 4/25
REFERENCE:		

PURPOSE:

Montefiore Mount Vernon is guided by a mission to provide high quality care for all its patients. We are committed to serving all patients, including those in our service area who lack health insurance coverage and who cannot pay for all or part of the essential care they receive. We are committed to treating all patients with compassion, from the bedside to the billing office, including our payment collection efforts. Furthermore, we are committed to advocating for expanded access to health care coverage for all New Yorkers.

We are committed to maintaining a Financial Assistance Policy (FAP) that is consistent with its mission and values and that considers an individual’s ability to pay for medically necessary health care services. This policy will constitute the official Financial Assistance Policy (within the meaning of Section 501(r) of the Internal Revenue Code of 1986, as amended, Section 1.501(r) of the Internal Revenue Service’s regulations promulgated thereunder and New York Public Health Law).

Definitions:

Amounts Generally Billed (AGB): the charge amounts generally billed for Covered Services provided to individuals who have insurance covering such care. The Hospital uses a percentage of gross charges (the AGB percentage) and has elected to use the “look-back” method to determine AGB. Generally, in calculating the AGB percentage under the look-back method, the Hospital must include the claims allowed during a prior 12-month period by: (a) Medicare fee-for-service; (b) Medicare fee-for-service and all private health insurers that pay claims to the hospital facility; or (c) Medicaid, either alone or in combination with Medicare fee-for-service or Medicare fee-for-service and all private health insurers that pay claims to the hospital. Please refer to the charts in Attachment A to this Policy for more information or contact a Financial Counselor at 914-365-3812.

Application Period: the period during which the Hospital must accept and process an application for financial assistance under the FAP.

Billing Deadline: the date after which the Hospital may initiate an ECA (as defined) against a Responsible

Individual (as defined) who has failed to submit an application for financial assistance under the FAP. The Billing Deadline must be specified in a written notice to the Responsible Individual provided at least 30 days prior to such deadline.

Emergent Condition: a medical condition that has resulted from the sudden onset of a health condition with acute symptoms of sufficient severity (including severe pain) which, in the absence of immediate medical attention, are reasonably likely to place the patient's health in serious jeopardy, result in serious impairment to bodily functions or result in serious dysfunction of any bodily organ or part.

Emergency Medical Care: medical care required to be provided for Emergent Conditions pursuant to the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act (42 U.S.C. 1395dd) to individuals, regardless of their eligibility for Financial Assistance under this policy. More specifically, Emergency Medical Care refers to services required to be provided under Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations and Treas. Reg. § 1.501(r)-4(c) (or any successor regulations), to the extent such regulations are applicable to the Hospital.

Extraordinary Collection Action (ECA): actions taken by the Hospital against an individual relating to obtaining payment of a bill for care covered under this FAP. (i.e., Garnishment of wages or forced sale of primary home).

FAP-Eligible Individual: an individual eligible for financial assistance under this Policy without regard to whether the individual has applied for financial assistance.

Hospital: Montefiore Mount Vernon and its substantially related entities.

Medically Necessary: as per Centers for Medicare and Medicaid, services or supplies that are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

Patient Accounts Department: the operating unit of the Hospital responsible for billing and collecting self-pay accounts for hospital services.

Plain Language Summary of the FAP (PLS): a written statement that notifies an individual that the Hospital facility offers financial assistance under a FAP and provides necessary information in language that is clear, concise, and easy to understand. The PLS must be offered at intake or discharge and in any bill notifying a Responsible Individual about a possible ECA.

Responsible Individual: the patient and any other individual having financial responsibility for the patient's account. There may be more than one Responsible Individual.

Covered Services: Emergency Medical Care (as defined) or other Medically Necessary (as defined) services provided to the hospital's inpatient and outpatients.

Elective procedures: Elective surgery or elective procedure is surgery that is scheduled in advance because it does not involve a medical emergency.

Approval Authority: Senior Leadership (which includes Assistant Vice President of Revenue Cycle; Associate Vice President, Professional Services; Vice President, Revenue Cycle or CFO) that have the authority to provide exception approval for any instance outside what is covered in the policy.

POLICY GUIDELINES:

This policy is intended apply to covered services rendered within Montefiore Mount Vernon. It provides guidelines for administering financial assistance to patients requiring emergency and medical necessary care who lack sufficient health insurance coverage or after exhausting all sources of insurance payment. Financial aid is provided to patients with a demonstrated inability to pay, as contrasted to an unwillingness to pay, which is considered bad debt.

This policy covers Montefiore Mount Vernon Hospital.

Please see Attachment B for other healthcare facilities covered by this policy. If a site is not listed a patient can email the financial aid department at NRFinancialAssistance@montefiore.org or call/visit any of the financial aid offices at 16 Guion Place, New Rochelle, NY (Main Cashiers Office) 914-365-3812.

The policy is reviewed annually.

As required by Federal law, services that are furnished at Federally Qualified Health Center (FQHC) sites to patients are subject to the Bronx Community Health Network (BCHN) and the Community Pediatric Programs sliding fee scale policy (JF15.1). Additionally, in compliance with Ryan White HIV/AIDS Program legislation, persons living with HIV/AIDS with incomes Household Income or Patients Income less than or equal to 100% of the federal poverty level will not be charged for services received in the Center for Positive Living/Infectious Disease Clinic”.

Patients cannot be denied admission or treatment/services because of an unpaid medical bill.

1. Financial aid shall be available to:

- Uninsured and Underinsured patients residing in the hospital’s primary service area receiving medically necessary services or emergency care (See Attachment A for Financial Aid Chart, Levels and covered primary service area for each entity)
- Patients residing in the hospital’s primary service area that exhausted their medical benefits for medically necessary or emergent care.
- Except for emergency services, patients need to reside within the hospital’s primary service area for a particular service to be categorically eligible for financial aid.
- Eligibility for financial assistance for non-emergent care for non-residents of New York State will be determined on a case-by-case basis and requires senior leadership approval.
- If patient is approved to receive financial assistance as an exception, they will be screened using same criteria as patients residing in the primary service area (gross income and family size tied to federal poverty level).

- Elective procedures that are not deemed medically necessary (e.g., cosmetic surgery, infertility treatment) are not eligible for financial aid. Patients can obtain a self-pay rate for non-covered services.
 - Patients who have health insurance but have spent more than 10% of their income on out-of-pocket medical expenses and are at or below 400% of FPL are also eligible for financial assistance
 - Foster Children/Children that reside in group homes
 - Accounts returned from a secondary collection agency where the FPL information is available, and patients are under 200% of the FPL
2. The Financial Aid policy follows EMTALA guidelines.
 3. 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.
 4. As of January 1st, 2018, charges for services which are denied by a Medicaid HMO payer as non-covered will also be considered for charity care.
 5. Any exceptions to the limits shall be made on a case-by-case basis and require approval.
 6. The Hospital does not place a limit on services based on a patient's medical condition.
 7. Financial aid office where patients can apply for assistance are located at: 12 North 7th Avenue Mt. Vernon, NY 10551 Main Cashiers Office, 914-361-6899.

Paper copies of the Financial Aid policy, the Financial Aid summary, and/or the Financial Aid application are available upon request, without charge, by mail or by E-mail. E-mail requests can be sent to MVFinancialAssistance@montefiore.org.

Copies are also available on each facility website at <http://www.montefiorehealthsystem.org/body.cfm?id=69>.

Information about Financial Aid will be available at discharge on after visit summary.

8. Determination of eligibility for financial aid will be made as early in the care planning and scheduling process as possible. Counselors will assist any patients who require assistance with completing financial aid applications. Emergency services will never be delayed pending financial determinations. Patients can apply for financial aid prior to services or after receipt of a bill. Patients can also apply for financial aid after a bill has been sent to a collection agency. There is no deadline for when a patient can request to complete a financial aid application.

9. Financial aid approvals will be valid for one year. Patients will be re-evaluated for financial aid annually.
10. Patients or financially responsible parties are expected to cooperate with the hospital in applying for available public insurance coverage (e.g., Medicaid, Child Health Plus, and Qualified Health Plans (during open enrollment) if deemed potentially eligible. Financial aid eligibility is not contingent on completing a Medicaid application nor will a decision be delayed pending a Medicaid decision.
11. Household or Patient's gross income tied to published Federal Poverty Level income guidelines adjusted for family size shall be used to determine eligibility for financial aid. Decisions are based on annual income only. Assets are not considered.
12. Hospital shall verify current income. Acceptable proof of Household or Patients income is as follows:
 - Social Security/pension award letter
 - Unemployment Statement
 - Pay stubs/employment verification letter
 - Letter of support
 - Attestation letter explaining income, support, and/or current financial situation if other proof of income is not available
 - Tax Returns or W2's (if patient requests to supply as proof of income but this is not required documentation)
13. Presumptive eligibility may also be based on prior FAP Eligibility, or hospital may use enrollment in certain specified means-tested public programs to presumptively determine that individuals are FAP-eligible, including:
 - State-funded prescription programs.
 - Homeless or received care from a homeless clinic.
 - Participation in Women, Infants and Children programs (WIC).
 - Food stamp eligibility.
 - Subsidized school lunch program eligibility.
 - Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down).
 - Low income/subsidized housing is provided as a valid address; and
 - Patient is deceased with no known estate.
 - Patient is eligible for emergency services Medicaid and was seen in the Emergency Room or Admitted emergently but Medicaid denied claim (excludes transplant and CAR-T).
 - Patient is approved for Patient Assistance program and has prior bills not covered by the approval for the grant or copay assistance program.
 - Foster Children/Children that reside in group homes
 - Secondary Agency closeouts where FPL information is available and patient is under 200% of the FPL

14. Hospital may use predictive analysis to assist in charity care determination in the absence of completed financial aid applications. Such findings will not deem a patient ineligible for financial assistance. If a patient completes a financial aid application with documentation demonstrating that his/her income (income type) is lower than the category determined using predictive analysis, the patient's financial responsibility will be further reduced to the lower amount.
15. Finance staff will be available to assist with financial aid consultations. Applications for financial aid will be reviewed and decided upon promptly and within 30 business days for non-emergency services. Patients have 30 days to appeal an initial financial aid decision. Patients will receive financial aid decisions via mail, with notification on the bottom of the approval/denial letter explaining how to appeal the decision. Patients are advised to disregard any bill received while an application is in process. Accounts for patients who have completed financial aid applications shall not be sent to collections while applications are in process. Responsible Individual appealing financial aid decisions must provide proof of current Household or Patients income and expenses. Responsible Individual has 30 days to complete appeals applications and will be notified of decisions via mail within 30 days of the submission of appeals applications. Based upon the information provided, patients may be evaluated for further reductions or extended payment plans.
16. Notice of the hospital's financial aid policies shall be communicated to patients, staff and local community service agencies. The hospital's financial aid policy shall be available in multiple languages (languages available dependent on the facility you are using) to any party seeking such information at the following locations:
- Admitting Offices
 - Business Offices
 - Emergency Room Registration office
 - Hospital's website: <http://www.montefiorehealthsystem.org/body.cfm?id=69>.
 - By mail upon request
 - By contacting: 914-361-6899
 - By emailing: MVFinancialAssistance@montefiore.org

Availability of Financial Aid is publicized on the following but not limited to list below:

- On all Hospital statements
- Signs are posted at entranceways advising patients of the room locations for financial aid
- E-screens on All Associates Computers and Waiting room Televisions
- Hospital's website: <http://www.montefiorehealthsystem.org/body.cfm?id=69>.
- As a Question and Informational packet on Annual Non-Clinical In-service
- Wall signage in the Emergency Department, Admitting Office, Billing and Medicaid offices and other registration and waiting areas

All Internal and External patient support staff are trained on the financial aid policy. An in-service is provided to all areas with instructions on where to send patients who need assistance.

17. Responsible Individual is offered payment plans if they are not able to make payments based on self-pay rate in full.

18. Hospital maintains a separate billing and collections policy. It can be found on the hospital website, or a hard copy can be requested by contacting financial aid office.
19. Responsible Individuals will receive a written notice 30 days prior to any account being forwarded to a collection agency or the initiation of any ECA for failure to request or complete a financial aid application or failure to make payments on a financial assistance balance. A reasonable effort to orally notify the responsible individual by telephone at the last known telephone number must also be made.
20. The hospital prohibits collections against any patient who is eligible for Medicaid at the time services rendered.
21. The Hospital may bill patient when they are non-compliant with Coordination of Benefits (COB) update and/or non-compliant with No Fault /Worker's Compensation insurance.
22. All hospital external patient support resources have a copy of the financial aid policy and will refer any patient needing assistance back to the hospital for evaluation and reduction of a bill based on annual income and family size.
23. Hospital measures compliance through semiannual audits of the intake and registration areas to ensure that signage and summaries are posted and available and that Associates are aware that the hospital offers financial aid.
24. Full financial aid will be granted to patients with outstanding self-pay bills and current Medicaid coverage.
25. Full Financial Aid will be granted to patients who are homeless. Ambulance Reports can be a source of reference if it is documented in the report that the patient is undomiciled.
26. Full Financial Aid will be granted to uninsured and underinsured minors receiving care in the hospital's school health clinics.
27. Immigration status is not a criterion used to determine eligibility.
28. Hospital's statements will reflect applicable financial aid or self-pay amounts.
29. The hospital does not use extraordinary collection measures. The extraordinary collection measures we do not use includes:
 - Reporting to credit agencies
 - Forced Sale of Primary residence
 - Place Liens
 - Sell debt
 - Refuse Service due to unpaid medical bills
 - Garnishing of Wages
 - Sue
 - Legal Action

30. Patients with any complaints about hospital's financial aid policy or process may call the New York State Department of Health Complaint Hotline at 1-800-804-5447. This information is also included on denial letters.

31. Hospital will ensure that translations of the FAP, PLS and Application will be made into the primary language spoken by individuals that use the hospital that constitute the lesser of 1,000 people or 5% of the community serviced.

Any exceptions to the limits above shall be made on a case-by-case basis and require the approval of senior leadership. In implementing this policy, hospital management and facilities shall comply with all other Federal, State, and local laws, rules, and regulations that may apply to activities conducted pursuant to this.

Attachment A: Federal Poverty Level and Financial Aid Rates

2026					
Federal Poverty Level	1	2	3	4	5
Family Size	BELOW 200%	200%-300%	301%-400%	401%-500%	over 500%
1	\$31,920	\$47,880	\$63,840	\$79,800	
2	\$43,280	\$64,920	\$86,560	\$108,200	
3	\$54,640	\$81,960	\$109,280	\$136,600	
4	\$66,000	\$99,000	\$132,000	\$165,000	
5	\$77,360	\$116,040	\$154,720	\$193,400	
6	\$88,720	\$133,080	\$177,440	\$221,800	
7	\$100,080	\$150,120	\$200,160	\$250,200	
8	\$111,440	\$167,160	\$222,880	\$278,600	
For each additional person Add.	\$11,360	\$17,400	\$22,720	\$28,400	
* Based on the 2026 Federal Poverty Guidelines					

Key Highlights:

- Montefiore Mount Vernon's primary service area is New York State. Patients residing outside of New York State that receive emergency care are eligible for financial assistance.
- Patients with prior debt at the hospital are not excluded from financial aid.
- Patients receiving outpatient care are not excluded from financial aid.
- Aid is available provided to patients with large medical bills if they otherwise do not qualify for free or discounted care. Patient Financial Services representatives will assist patients with available options.
- For the hospital rates for up to 500% of FPL there is a comparison to the Amount Generally Billed and the patient is responsible for the lesser of the two.
- A comparison of the AGB % to the financial aid category rate is completed for patients that fall at or below 100% of FPL up to 500% of FPL. The capped amount for Hospital Services in Attachment A are as follows (up to 500% of FPL):
 - ED visit rate is not to exceed 47% of hospital charges incurred.
 - Ambulatory surgery rate is not to exceed 27% of hospital charges incurred.
 - Clinic Visit/Pathology/Referred Ambulatory are not to exceed 14% of hospital charges incurred.
 - Emergency Inpatient Admission rate is not to exceed 28% of hospital charges incurred.

Uninsured

Pricing Levels	% FPL	Montefiore Mount Vernon Emergency Room Visits
1	Below 200%	\$0
2	200-300%	10% of Medicaid
3	301-400%	20% of Medicaid
4	401-500%	\$700
5	>500%	\$1500

Pricing Levels	% FPL	Montefiore Mount Vernon Emergency Inpatient Admissions
1	Below 200%	\$0
2	200-300%	10% of Medicaid
3	301-400%	20% of Medicaid
4	401-500%	\$11,000 per discharge
5	>500%	\$16,000 per discharge

Pricing Levels	% FPL	Montefiore Mount Vernon's Clinic Visits (for Practice locations, Mental Health Clinics, Oncology Office visits, Renal Clinic, Laboratory and Pathology)
1	Below 200%	\$0
2	200-300%	10% of Medicaid
3	301-400%	20% of Medicaid
4	401-500%	\$200
5	>500%	\$350

Pricing Levels	% FPL	Montefiore Mount Vernon Medically Necessary Procedures- Ambulatory (excluding Gastrointestinal)
1	Below 200%	\$0
2	200-300%	10% of Medicaid
3	301-400%	20% of Medicaid
4	401-500%	\$3,500 per procedure
5	>500%	\$5,000 per procedure

Pricing Levels	% FPL	Montefiore Mount Vernon Medically Necessary Procedures- Gastrointestinal
1	Below 200%	\$0
2	200-300%	10% of Medicaid
3	301-400%	20% of Medicaid
4	401-500%	\$,1800 per procedure
5	>500%	\$2,500 per procedure

Pricing Levels	% FPL	Montefiore Mount Vernon Radiology: X-Ray
1	Below 200%	\$0
2	200-300%	10% of Medicaid
3	301-400%	20% of Medicaid
4	401-500%	\$50
5	>500%	The self-pay discount at 100% Blue Cross indemnity rate

Pricing Levels	% FPL	Montefiore Mount Vernon Radiology: Ultrasound
1	Below 200%	\$0
2	200-300%	10% of Medicaid
3	301-400%	20% of Medicaid
4	401-500%	\$100
5	>500%	The self-pay discount at 100% Blue Cross indemnity rate

Pricing Levels	% FPL	Montefiore Mount Vernon Radiology: Mammogram
1	Below 200%	\$0
2	200-300%	10% of Medicaid
3	301-400%	20% of Medicaid
4	401-500%	\$130
5	>500%	The self-pay discount at 100% Blue Cross indemnity rate

Pricing Levels	% FPL	Montefiore Mount Vernon: Computed Tomography (CT)
1	Below 200%	\$0
2	200-300%	10% of Medicaid
3	301-400%	20% of Medicaid
4	401-500%	\$250
5	>500%	The self-pay discount at 100% Blue Cross indemnity rate

Pricing Levels	% FPL	Montefiore Mount Vernon Radiology: MRI
1	Below 200%	\$0
2	200-300%	10% of Medicaid
3	301-400%	20% of Medicaid
4	401-500%	\$550
5	>500%	The self-pay discount at 100% Blue Cross indemnity rate

Underinsured

Patients who have health insurance, but have spent more than 10% of their income on out-of-pocket medical

Income Level	Payment
Below 200% FPL	Waive all charges
200% - 300% FPL	10% of the amount that would have been paid pursuant to such patient's insurance cost sharing.
301% - 400% FPL	20% of the amount that would have been paid pursuant to such patient's insurance cost sharing.

Approved by: *Colleen Blye*

Colleen Blye
Executive Vice President, CFO & CBO

Date: June 3, 2026