Exhibit C

2020 SJMH Charity Care guidelines

Poverty Guidelines-HHS		**Family Unit Size**							
As published in the Federal Register 02/06/2020,effective 01/17/2020 48 Contiguous States & the District of Columbia, for each additional family member add $4,420.	**Financial Liability per pt statement**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
		12,760	17,240	21,720	26,200	30,680	35,160	39,640	44,120
Incomes at or below 200% of guidelines	Zero AFSP-FULL	25,520	34,480	43,440	52,400	61,360	70,320	79,280	88,240
Incomes at or between 201%-250%	40% of expected Excellus BC rate AFSPBC AFSP-60%	31,900	43,100	54,300	65,500	76,700	87,900	99,100	110,300
Incomes at or between 251%-300%	100% of Excellus BC expected reimbursement AFSPBC	38,280	51,720	65,160	78,600	92,040	105,480	118,920	132,360

Exhibit A

ST JAMES HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

411 Canisteo St
Hornell NY 14843

Please return by: _____

A. - Patient Financial Information

		Patient / Guarantor # 1	Spouse / Guarantor # 2
1	First name, middle initial (please print)		
2	Street address:		
3	City, state, zip code		
4	Social security number		
5	Day phone (area code)		
6	Are you employed?	_____ YES ___NO	_____ YES ____NO
7	Are you self-employed?	_____ YES ___NO	_____ YES ____NO
	If you answered yes to # 6 or 7, go to # 9; if answered no, go to # 12.		
8	Name of employer/company		
9	Employer/company street address:		
10	City, state, zip code		
11	How long have you worked here?	_____ Years ____ Months	_____ Years ____ Months
12	Number of dependents		
	List dependents below (please print all information)	Dependent # 1	Dependent # 5
	Name: first, middle initial, last		
	Date of birth: Month/day/year		
	Social security number:		
	Relationship of dependent to you:		
		Dependent # 2	Dependent # 6
	Name: first, middle initial, last		
	Date of birth: Month/day/year		
	Social security number:		
	Relationship of dependant to you:		
		Dependent # 3	Dependent # 7
	Name: first, middle initial, last		
	Date of birth: Month/day/year		
	Social security number:		
	Relationship of dependant to you:		
		Dependent # 4	Dependent # 8
	Name: first, middle initial, last		
	Date of birth: Month/day/year		
	Social security number:		
	Relationship of dependant to you:		

St James Hospital

FINANCIAL ASSISTANCE APPLICATION

B. - HOUSEHOLD FINANCIAL DATA **MONTHLY INCOME & EXPENSE**	Patient / Guarantor # 1	Spouse / Guarantor # 2
MONTHLY INCOME		
1 Gross salaries, wages before taxes		
2 Business Income		
3 Rental Income		
4 Investment Income		
5 Income from Estates/Trusts		
6 Social Security		
7 Aid to Dependant Children		
8 Public Assistance Income		
9 Other Income (list amount & source) (lines 10-11)		
10 MEDICAID DENIAL		
11 NYS EXCHANGE DETERMINATION		
12 Totals	0	0
13 Total Income All Sources	0	
MONTHLY EXPENSES		
14 Mortgage Payment		
15 Rent payment		
16 Car payment(s)		
17 Child care / Day care expenses		
18 Gas & water utilities		
19 Electricity		
20 Telephone		
21 Insurance payment(s)		
22 Other loan payment(s)		
23 Credit card payment(s)		
24 Other medical bills		
25 Other expenses (specify type) (lines 30-32)		
26 Transportation		
27 Taxes		
28 Solid Waste		
29 Home owers ins		
30		
31 Totals	0	0
32 Total Expenses all types	0	
34 Net Income/(Expense) (line 13 less 34)	0	

ST. JAMES MERCY HEALTH
FINANCIAL ASSISTANCE APPLICATION

C. - FINANCIAL DATA ASSET LIQUIDITY TEST	Patient / Guarantor # 1	Spouse / Guarantor # 2
ASSETS		
35 Cash on hand over $500		
36 Checking Account(s) balance over $500		
38 Savings Account(s) balance over $500		
39 Stocks current value		
40 Bond(s) current value		
41 Rental property assessed value		
42 Business property assessed value		
43 Jewelry estimated value		
44 Recreational Vehicle(s) estimated value		
45 Boat(s) estimated value		
46 Other assets (specify) (lines47-48)		
47		
48		
49 Totals	0	0
50 Total Assets	0	
LIABILITIES		
51 Rental property loan balance		
52 Business property loan balance		
53 Recreational Vehicle(s) loan balance		
54 Boat(s) loan balance		
55 Total Credit Card Debt		
56 Other Medical Bills, list:		
57 Other Liabilities, list type & amount (lines 58-61)		
58		
59		
60		
61		
62 Totals	0	0
63 Total Liabilities	0	

ST. JAMES MERCY HEALTH
FINANCIAL ASSISTANCE APPLICATION

		circle one:
64	Are you a single parent?	YES / NO
65	Do you care for an elderly parent or disabled child in your home?	YES / NO
66	Are you in the process of filing bankruptcy?	YES / NO

Were you denied Medicaid coverage? YES / NO

Other information which you want considered as part of this application:

_____

_____

_____

_____

_____

Once you have completed this application, and returned it with all requested documentation, you may disregard all potentially eligible bills from St. James Mercy Hospital until you have been notified of a decision.

St. James reserves the right to rescind any discounts and/or deny your application for Charity Care if you are found to have knowingly provided false information or documents.

You are obligated to notify St. James of any income changes during your eligibility period.

St. James Mercy requires re-verification of your income for any inpatient admission.

I hereby acknowledge that the above information is true and accurate to the best of my knowledge. I have no income or assets other than those listed above. I have provided St. James Mercy Health with all insurance benefits available, and exhausted all other possible sources of payment for my care.

I am also aware that any monies paid on accounts that have a charity care adjustment will not be refunded to me.

I further grant St. James Mercy Health authorization to verify any or all information given, and also authorize a consumer credit report if necessary.

_____

Patient/Guarantor # 1 -Signature **Date**

_____

Spouse/Guarantor # 2- Signature **Date**

Required Documentation: See attached list (Exhibit B)

ST JAMES HOSPITAL
Patient Financial Assistance - Adjustment Worksheet

(1) Patient Name: _____

(2) Patient Medical Record #: _____

(3) Patient account number(s) _____ _____

(4) Patient account balance: $ _____
(Total amount due from patient for all accounts listed above on Line # 3)

Section A. - Income Criteria

(5) Combined annual income $ 0
all sources

(6) Family size including all
dependents

(7) Poverty Guidelines $
(see Exhibit C)

(8) Annual income as % of % #DIV/0!
Poverty Guidelines

(9) Financial Assistance Adjustment %
(see Exhibit C)

(10) Recommended Adjustment $ 0
based on income

Section B. - Asset Criteria

(11) Combined annual income $ 0

(12) Net worth (assets - liabilities) 0

(13) Subtract living expenses 0

(14) Amount Available to pay charges $ 0 If line14 is a negative amt. STOP HERE &
(Line 11 + 12 -13 = 14) see line 9 for recommended adjustment.
If line 14 is a positive amt. continue to line 15

(15) Income % of poverty level guidelines #DIV/0!
with consideration of assets & liabilities

(16) Financial Assistance Adjustment Level
based on income from line 14 (Exhibit C)

Level 1: The patient has no liability. 100% adjustment for all medically necessary services.
Level 2: The patient is responsible for paying 40% of the Excellus Blue Cross rate.
Level 3: The patient is responsible for paying 100% of the Excellus Blue Cross rate.

Did the patient qualify for MA/FHP? _____
If no, give reason:_____
_____

Did the patient qualify for Special Circumstances? _____
If yes, please explain:
_____
_____
_____
_____
_____

Other Comments:
_____
_____
_____
_____
_____

Adjustment worksheet completed by Date

Financial Counselor approval Date
$1 - $1,000

Manager,Patient Access and Self Pay Date
$1,001 - $10,000

Director of Revenue Cycle Date
$10,001 - $25,000

Chief Financial Officer Date
$25,001 and above

Chief Executive Officer Date
$25,000 and above

Exhibit B

Please call 607-324-8067 with any questions

PROCESSING MAY TAKE UP TO 30 DAYS AFTER YOU HAVE RETURNED APPLICATION

Required Documentation for SJMH Charity Care Application:

Gross Income:	Last 4 week's pay stubs with year-to-date total If pay stubs not available, last year's tax return Social Security notice (preferred vs. S.S. pay stub) Rental Income documents Any other source of income documents **Exclude:** Child support and/or alimony received
Expenses:	Copy of statement/last bill for any expense listed on application. Including but not limited to: Mortgage or rent payments Taxes (if not included in mortgage payment) Car loan payments Other loan payments Daycare Utilities: Gas, Water, Electricity Telephone bills Insurance payments for: Auto Home owners Health Ins Gas for cars up to $100 per month Credit card payments Medical bills for other hospitals Prescriptions – out of pocket portion Other expenses reviewed case by case
Assets:	Copy of statement or appropriate documentation for assets listed Including but not limited to: Checking account balance over $500 Savings account balance over $500 Rental Property Autos except primary vehicle Recreational Vehicles
Liabilities:	Copy of statement or documentation for liabilities listed Allowed liabilities: Mortgages Taxes Auto and other loan balances Credit card balances Medical care balances from other facilities Other liabilities reviewed case by case
Other:	Copy of compliant Medicaid decision letter (REQUIRED)

St. James Mercy Health
Patient Financial Assistance
Adjustment Worksheet Instructions

Section A. - Income Criteria

Step 1. Complete line **# 5** - Combined annual income from all sources
Take annual income from tax return(s):
Schedule 1040 - line 22 Total Income
Schedule 1040EZ - line 4 adjusted gross income

Divide annual income by 12, compare to monthly income shown on the Financial Assistance Worksheet.

Use the higher monthly income amount (tax return or worksheet) to calculate annual income and put on line **# 5.**

Step 2. Complete line **# 6** - Family size including all dependents
Show family size based on worksheet family information **# 13**

Step 3. Complete line **# 7** - Current HHS Poverty Guidelines
Complete based on state of residency and family size
See Appendix A for HHS Poverty Guidelines

Step 4. Complete line **# 8** - Annual Income as % of HHS Poverty Guidelines
Divide line **# 5** by line **# 7**

Step 5. Complete line **# 10** - Recommended Adjustment based on income
Multiple line **# 4** by line **# 9**. Patient is eligible for adjusment based on the following guidelines in appendix A.

If patient's income is greater than 300% of HHS poverty guidelines they are not eligible for any adjustment, and there is no need to complete asset criteria test.

St. James Mercy Health
Patient Financial Assistance
Adjustment Worksheet Instructions

Section B. Asset Criteria

Step 6. Complete line **# 11** - Combined annual income
copy from line # **5**

Step 7. Complete line **# 12** - Excess Liquid Assets
Use Financial Assistance Application line **# 50** Total Assets
minus line **# 63** Total Liabilities = Net Assets (if negative enter zero).
Net asset total - average monthly income (from Step 1) X 2 = Excess Liquid Assets

Step 8. Complete line **# 13** - Living Expenses
Use Financial Assistance Application line **# 34** total expenses times 12.

Step 9. Complete line **# 14** - Amount available to pay
Equals line **# 11** + line **# 12** - line **# 13**.
*if line 14 equals a negative amount stop here. The pt is elig for the adjustment shown on line **9**.
*if line 14 is a positive amount continue to the next step.

Step 10. Complete line **# 15** - Annual Income as % of HHS Poverty Guidelines
Divide line **# 14** by line **# 7**

Step 11. Complete line **# 16** - Recommended adjustment based on assets
Equals line **# 4** multiplied by line **# 17**

SJMH Financial Assistance

Eligible Charges

All charges billed by SJMH will be eligible for the Financial Assistance Program. However,

- Only patient balances remaining after patient/guarantor has exhausted all efforts to obtain coverage from State or Federally funded programs (i.e. Medicaid, Title V, etc.) as directed by Patient Access or the billing department are eligible for the plan.
- Patient deductibles or co-insurance amounts recoverable under the Medicare bad debt procedures are not eligible for indigent care write-off. (Proof of indigence enables a patient's eligibility for classificationas a Medicare bad debt and therefore recoverable from the Medicare Program.)
- Accounts related to deceased individuals lacking an estate, or having an inadequate estate will qualify or partially for Financial Assistance depending on the circumstances.

Exclusions

- Elective abortions and reversal of voluntary sterilization
- Exams for purpose of certifying health to outside agency
- Cosmetic procedures or non-medically necessary services
- Custodial care, domiciliary care
- Personal comfort and convenience items
- Services for achieving pregnancy (invitro, GIFT, ZIFT, artificial insemination) & Surrogate motherhood

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Exhibit D

Authorization for Charity Care

$1- $1,000	Approval needed from FC (Financial Counselor)
$1,001 - $10,000	Approval needed from FC & Patient Access Manager
$10,001 - $25,000	Approval needed from FC, Business Office Manager, & Director of Revenue Cycle
$25,001 and above	Approval needed from FC, Business Office Manager, Director of Revenue Cycle, CFO, & CEO