

# COOPER UNIVERSITY HEALTH CARE

## Corporate Policies and Procedures

Supersedes:	03/30/2016	Section:	Finance
Reviewed:	05/02/2019	Subject:	2.206 - Charity Care Procedure

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**Notice: The official version of this Policy is contained in Cooper Policy Network and may have been revised since the document was printed.**

I. PURPOSE:

- A. To define the procedure and guidelines for providing Charity Care to those individuals who are unable to pay for all or a portion of their hospital bill

II. SCOPE:

- A. Cooper University Hospital (“Cooper”) is an academic medical center committed to providing world-class patient care, education, and research resulting in a healthier community. Cooper University’s mission is to provide every patient outstanding care regardless of their ability to pay.
- B. Cooper will provide Charity Care (as defined below) to those uninsured patients who are unable to pay based upon the eligibility criteria set forth herein.
- C. Charity Care is a state sponsored program that allows uninsured and under insured patients to receive care at reduced rates if deemed eligible; eligibility is based on income and asset criteria. This Charity Care procedure applies to all medically necessary health care services that Cooper provides to New Jersey residents including inpatient and outpatient hospital services.
- D. This procedure is limited to hospital charges and does not include physician, anesthesiologist or other professional charges. For discounts and other financial assistance offered to uninsured patients for physician services, see Corporate Procedure [2.205 - Charity and Self-Pay Discount Procedure](#). In addition, this procedure does not apply to prescriptions and durable medical equipment.
- E. This procedure applies to New Jersey residents only. Charity Care may be offered to non-New Jersey residents requiring immediate medical attention for an emergency medical condition.
1. To learn more about the state of New Jersey’s charity care program visit their web site at [www.state.nj.us/health/charitycare/index.shtml](http://www.state.nj.us/health/charitycare/index.shtml)
- F. For patients who do not qualify for charity care and are uninsured you may be entitled to a self-pay discount in compliance with New Jersey Legislature, PL 1971, and c 136.

III. DEFINITIONS:

- A. **Charity Care:** is either
1. Free care provided to patients who are uninsured for the relevant, medically necessary service, who are ineligible for private or governmental sponsored

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health care coverage, who have family incomes not in excess of 200% of the Federal Poverty Income Guidelines (“FPIG”) and individual assets not exceeding \$7,500 or family assets not exceeding \$15,000; or

2. Discounts afforded patients who are uninsured for the relevant service, who have family incomes in excess of 200% but not exceeding 300% of the FPIG\* and individual assets not exceeding \$7,500 or family assets not exceeding \$15,000.

Income as a Percentage of FPIG	Percentage of 115% of Medicare Rate Paid by Patient**
less than or equal to 200%	0%
greater than 200% but less than or equal to 225%	20%
greater than 225% but less than or equal to 250%	40%
greater than 250% but less than or equal to 275%	60%
greater than 275% but less than or equal to 300%	80%
greater than 300% but less than or equal to 500%	100%

\*The FPIG is updated each year in February and can be located at:

<http://aspe.hhs.gov/poverty/index.shtml>.

\*\*For patients with incomes between 200% and 300% of the FPIG, the sliding scale discount applies to 115% of the applicable Medicare rate for the service rendered.

- B. **Self-Pay Patient:** Those patients who are uninsured patients (as defined below) and who are not eligible for Charity Care. Self-Pay Patients with family gross income less than 500% of the FPIG will not be billed amounts that exceed 115% of applicable Medicare rates. Self-Pay patients are eligible for financial assistance as outlined in Cooper’s Uninsured Patient Discounts procedure.
- C. **Uninsured Patient:** A patient who does not have any third party health care coverage by either (a) a third party insurer, (b) an ERISA plan, (c) a federal or state health care program (including without limitation Medicare, Medicaid, and TRICARE), (d) workers’ compensation, medical savings account or other coverage for all or any part of the bill, including claims against third parties covered by insurance to which a Cooper entity is subrogated, but only if payment is actually made by such insurance company.

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- D. **Governmental Sponsored Health Care Coverage:** Any health care program (other than Charity Care) operated or financed at least in part by the federal, state or local government.
- E. **Financial Counselor:** An individual trained to assist patients in identifying sources of healthcare coverage, determining eligibility for such coverage, and assisting in completing necessary applications. Financial counselors may either be employees of Cooper or a third party engaged by Cooper to assist in its billing and collections process. To apply for Charity Care at Cooper please contact our financial counselors at 856-342-3140.

#### IV. PROCEDURE:

##### A. General Principles:

1. All Charity Care applicants must be screened to determine the potential eligibility for any private or Governmental Sponsored Health Care Coverage that might pay the hospital bill. Patients may not be eligible for Charity Care until they are determined to be ineligible for any private or Governmental Sponsored Health Care Coverage.
2. Patients who do not provide all information necessary to completely and accurately assess their financial situation or who do not cooperate with efforts to secure Governmental Sponsored Health Care Coverage will be deemed ineligible for Charity Care. However, such cooperation will not be a precondition to the timely provision of medically necessary treatment.
3. Patients determined to be eligible for Charity Care shall not receive a bill for services or be subject to collection procedures. Patients determined to be eligible for reduced Charity Care shall not be billed or subject to collection procedures for the portion of the bill that is reduced charge Charity Care.
4. Length of Charity Care approval is specific to services rendered.
  - a. Emergency treatment is date of service only
  - b. Radiology and lab is 30 days
  - c. Inpatient stays are 60 days
  - d. Hematology and oncology is 180 days.
5. Patients will be eligible to reapply for Charity Care again after the applicable period has expired.
6. A Financial Counselor will, upon request, discuss with any patient, prospective patient or guarantor the details of this procedure, and the procedure's potential applicability to the circumstances of that patient or prospective patient.

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### B. Outpatient and Elective Inpatient Procedures:

1. At the time of scheduling, pre-registration or registration for outpatient or non-emergent inpatient procedures (whichever are applicable), the patient will be asked for insurance coverage, and the patient will be informed of any co-payments that will be expected at the time of payment. If the patient is an uninsured patient, the patient will be informed of the procedure. If the patient wishes to apply for Charity Care, he or she will be given or mailed an application. If the patient does not wish to apply for Charity Care, the patient will be informed of the amount due at the time of registration. A patient may not qualify for Charity Care until he or she has completed the Charity Care application.
2. After completing the Charity Care application (including supporting documentation as set forth below), the patient is expected to return to Cooper and meet with a Financial Counselor. A Financial Counselor will assess the application and determine whether a patient qualifies for Charity Care or Governmental Sponsored Health Care Coverage.
3. If the patient is likely to qualify for Governmental Sponsored Health Care Coverage, a Financial Counselor will assist the patient in applying for appropriate coverage.
4. If a patient is unlikely to qualify for Governmental Sponsored Health Care Coverage, and the patient does not qualify for Charity Care, appropriate payment arrangements must be made with a Financial Counselor. Should the patient subsequently qualify for Governmental Sponsored Health Care Coverage or any other health insurance, any payments received will be refunded less any co-payments due.

### C. Patients Treated and Released from Emergency Department:

1. All patients will be treated in accordance with the requirements of the Federal Emergency Medical Treatment and Labor Act. All patients will be triaged and, if medically necessary, receive a medical screening exam by Emergency Department staff prior to registration or obtaining information on insurance coverage.
2. Any uninsured patient will be informed of the process prior to discharge. A Charity Care application will be provided to any patient who wishes to apply for Charity Care. The patient shall be instructed to complete and return the application to the Financial Counselor.

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3. If an uninsured patient has been referred from the Emergency Room to a Cooper outpatient department for follow-up treatment, the patient will be informed that, at the time of the appointment, payment or a completed Charity Care application will be expected. Based on the information provided in the completed Charity Care application, eligibility for Medicaid or other Governmental Sponsored Health Care Coverage may also be considered.

D. Inpatients Admitted through the Emergency Department:

1. Within one business day following admission, a Financial Counselor will arrange a meeting with uninsured patients, to be held during the inpatient admission. The Financial Counselor will work with patients and their families to obtain information necessary to complete a Medical Assistance application and Charity Care application. If the Medical Assistance application and Charity Care application cannot be completed during the patient's admission, the Financial Counselor will follow up with the patient by telephone and request additional information.
2. Medical Assistance applications will be completed and forwarded to the New Jersey Department of Human Services, Division of Medical Assistance and Health Services ("DMAHS"). If the Medical Assistance application is approved, the patient's financial status will be updated and DMAHS will be billed. If a patient is denied Medical Assistance (or if it is determined that an application is not appropriate), the patient's case will be reviewed for Charity Care. If the patient does not qualify for Charity Care, appropriate payment arrangements must be worked out with the Financial Counselor.

E. Application Process:

1. In order for a formal determination of Charity Care eligibility to be made, it is necessary for the patient (or guarantor) to provide any and all information being requested, including but not limited to, demographic and financial information, as well as information documenting income resources and financial assets (e.g., W-2, pay stubs, tax forms, etc.) and proof of New Jersey residency. All such financial information will be held in confidence and will be used only for the purposes of evaluating a patient's eligibility for Charity Care.
2. The patient will be asked if he or she has any third party health insurance, including, but not limited to, coverage through a parent or spouse or coverage for the services under an automobile insurance or workers compensation policy. If the patient claims to have insurance, the name of the insurer and the insured will

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be documented by the Financial Counselor, who will also verify the coverage by contacting the identified third-party insurer.

3. The financial resources of a parent or guardian will be considered in determining the Charity Care eligibility of a patient who is a legal dependent.
4. A Charity Care application may be submitted at any time up to one year from the date of outpatient service or inpatient discharge.
5. Cooper shall make the Charity Care determination and notify the applicant, in writing, within ten (10) working days from the day the applicant submits a completed written application. If the application does not contain sufficient documentation to make the determination, Cooper shall notify the applicant, in writing, within ten (10) working days from the day the applicant submits an incomplete application. The applicant shall be permitted to supply additional documentation at any time up to one year after the date of inpatient discharge or outpatient service.
6. Once a patient has been approved for Charity Care, the patient must disclose any change in financial or family situation that may affect eligibility for Charity Care. The patient will be asked periodically to disclose any changes in status or update the financial and family information and may be asked to reapply for Charity Care.

F. Patient Notification of Charity Care Procedure:

1. Written notice of the availability of Charity Care and Medicaid or NJ FamilyCare shall be provided to patients at the time of service as outlined above.
2. Notification concerning the existence of Cooper's Charity Care procedure shall be posted within Cooper and its satellite facilities such as the admissions area, business office, outpatient clinic areas, the emergency room and the main hospital information desk.
3. Upon request, a copy of the Charity Care procedure will be made available in a reasonably timely manner by the Department of Financial Counseling.
4. The Charity Care Procedure is posted on the Cooper Policy Network (<https://cooperhealth.policytech.com>).

V. REFERENCES:

- A. N.J.S.A. §§ 26:2H-12.52-12.53 (effective February 4, 2009); Letter Bulletin from Commissioner of New Jersey Department of Health and Senior Services dated October 7, 2008
- B. N.J.A.C. §§ 10:52-11.1-11.16.



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APPROVED BY:

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