2014 CHARITY CARE GUIDELINES

Kaleida Health is committed to providing quality health care services at a reduced charge to eligible persons who cannot afford to pay for these services. Charity care is available to patients of families based on the following income and family size guidelines as determined by Federal poverty regulations as published by the New York State Department of Health and Human Services.

<table>
<thead>
<tr>
<th>Size of Family</th>
<th>Family Income Less Than:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Each Add’tl</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>23,340</td>
<td>29,175</td>
<td>35,010</td>
<td>40,845</td>
<td>46,680</td>
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<tr>
<td>2</td>
<td>31,460</td>
<td>39,325</td>
<td>47,190</td>
<td>55,055</td>
<td>62,920</td>
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<td>3</td>
<td>39,580</td>
<td>49,475</td>
<td>59,370</td>
<td>69,265</td>
<td>79,160</td>
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<tr>
<td>4</td>
<td>47,700</td>
<td>59,625</td>
<td>71,550</td>
<td>83,475</td>
<td>95,400</td>
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<tr>
<td>5</td>
<td>55,820</td>
<td>69,775</td>
<td>83,730</td>
<td>97,685</td>
<td>111,640</td>
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<tr>
<td>6</td>
<td>63,940</td>
<td>79,925</td>
<td>95,910</td>
<td>111,895</td>
<td>127,880</td>
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<tr>
<td>7</td>
<td>72,060</td>
<td>90,075</td>
<td>108,090</td>
<td>126,105</td>
<td>144,120</td>
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<tr>
<td>8</td>
<td>80,180</td>
<td>100,225</td>
<td>120,270</td>
<td>140,315</td>
<td>160,360</td>
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<td></td>
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<tr>
<td>Each Add’tl</td>
<td>8,120</td>
<td>10,150</td>
<td>12,180</td>
<td>14,210</td>
<td>16,240</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Discount on Charges</td>
<td>100%</td>
<td>90%</td>
<td>75%</td>
<td>60%</td>
<td>50%</td>
<td></td>
<td></td>
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<tr>
<td>Patient Share</td>
<td>0</td>
<td>10%</td>
<td>25%</td>
<td>40%</td>
<td>50%</td>
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REV.2.2014/SRW.
APPLICANT FOR CHARITY CARE DISCOUNT

Household Information

Complete information below for applicant(s): All sections need to be completed in full

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>DATE OF BIRTH</th>
<th>EMPLOYED/INCOME (Y) OR (N)</th>
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</table>

Complete information below for all other(s) living in the household:

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>DATE OF BIRTH</th>
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</thead>
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Address:

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<tr>
<th>HOME PHONE</th>
<th>CELLULAR PHONE</th>
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<tbody>
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ASSETS

List all bank accounts, (educational savings accounts retirement accounts excluded). Attach copies of bank statement(s) for the current and previous months (all pages).

BANK/CREDIT UNION ACCOUNTS:

Checking Acc#: __________________________
Bank Name: _______________________________
Balance: ________________________________

Savings Acc#: ____________________________
Bank Name: _______________________________
Balance: ________________________________

Note: Please submit copies of bank statements with this application. The applicant's name and address must be listed on the bank statements.

PROOF HOUSEHOLD MONTHLY INCOME

- Earned Wages: ________________
- Social Security: ________________
- Disability: ________________
- Unemployment: ________________
- Child Support: ________________
- Pension: ________________
- Alimony: ________________
- Dividends, Interest: ________________
- Rental Income: ________________
- Other Income: ________________

Note: Self-Employment: Please submit 3 Month Ledger. Signed dated and notarized

1). Do you currently have any insurance? If so, what insurance plan?

2). If you do not have insurance Have you spoken to a Facilitated Enroller?

3). If you currently do not have insurance Have you applied for Medicaid, Family Health Plus or Child Health Plus and or any other insurance plans on your own?

4). If yes, please provide proof of eligibility or denial:

__________________________________________
I certify that the information provided in this application is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges, and will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can assess my eligibility under the Kaleida Health Charity Care Policy. If any information I have given is untrue, I understand that the hospital may re-evaluate my financial status and take whatever action deemed appropriate.

I agree to provide additional information as requested in order to determine eligibility. I agree to inform Kaleida Health of any changes in my needs, insurance eligibility, living arrangements and address as they occur.

Signed: ___________________________ Date: __________________________

Signed: ___________________________ Date: __________________________

Pt Representative: ___________________________ Relationship: _______________

Date: __________________________

For Office Use Only:

△ Checked Eligibility: Patient has no active insurance for outstanding accounts/DOS

△ All required sections of the application are complete

△ All required documentation is submitted

Outstanding items: __________________________________________________________

_______________________________

△ Follow-up letter mailed to applicant. Date mailed: __________________________

△ Follow-up documents returned to Kaleida Health: Date received: ____________

△ Approved: Date: __________________________

△ Denied: ___________________________ Reason: ____________________________

Patient Financial Svc. Rep Signature: __________________________________________

A copy of this document must be kept in the applicants file
PROCESS FOR APPLYING FOR CHARITY CARE

To be considered for Charity Care you must complete all sections in full, if they do not pertain to you or the applicant please write ‘N/A’, date and sign the Charity Care Application and provide necessary documentation for processing. You may be contacted by a Facilitated Enroller for financial screening to assist you with enrollment in a government insurance program and, or our Charity Care Program. Consideration will be given to complete applications only.

Note: If your application for Medicaid, Family Health Plus, Child Health Plus or the Affordable Health Care Insurance is denied because you did not submit all of the information they require, your request for Charity Care will also be denied. All Charity Care applicants must apply for Medicaid and OR other government insurance programs to be considered for assistance. If denied, the applicant must submit a copy of a written denial and budget/screening sheet from the local department of social services, OR documentation from a Kaleida Health facilitated enroller, financial social worker OR subcontractor who performs these duties on behalf of Kaleida Health. If the applicant has been denied insurance for non-compliance he/she is not eligible for charity care consideration.

Submit a completed (signed and dated) application and the following items within 30 days of receipt of the Charity Care Application. Failure to provide this information will result in the denial of your application.

Proof of Income: The following are acceptable for proof of income:

- Last four (4) pay stubs from signature date for those who are paid weekly OR the last two (2) pay stubs for those who are paid bi-weekly for all members living in the household and are over the age of 21 years old.
- Social Security award letter from current year which outlines gross payment for all that receive in household
- Disability check stub which outlines payment amount and dates visible
- Unemployment statement printed from the department of labor website
- Child Support statement from the county/courts, OR direct deposit OR letter from the person paying the support notarized, signed and dated
- Official pension statement outlining the gross amount OR copy of the stub with gross amount noted
- Alimony statement from the county/courts, OR direct deposit OR letter from the person paying the support notarized, signed and dated.
- Dividends/Interest current documentation of amount and frequency received
- Rental Income current (within one year) receipt or lease agreement
- Other Income would include contributions from others. A statement outlining the amount and frequency received must be notarized, signed and dated. Students living off loans must submit a current Financial Aide Award Letter.
- Self Employed individuals must submit a current three (3) month business ledger (notarized, signed and dated)
- If unable to verify income, Kaleida Health will issue a denial for assistance and the patient must reapply (see Letter Regarding Notice of Denial below).
- Banks Statements (all pages) for all current (no more than 30 days from the signature date on the application. For example, if the application is signed in May, we require April’s bank statement) checking and saving accounts for all household members. Statements must outline all activity (withdraws/deposits) and may not be obscured in any way. Applicants must submit a letter of explanation for any deposit reflected on the bank statement of $1,000 or more. Only the first five (5) digits of the account number may be obscured for security.
- Accounts established for education, retirement and burials must be noted on the official statement. We will not accept a separate letter from the applicant.
- Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA) will be considered as assets when determining charity care eligibility.
- Provide a copy of your Medicaid, Family Health Plus and Child Health Plus approval or denial letter. The letter must be dated within the past six (6). If not within the last six (6) months our Facilitated Enroller will assist with rescreening you for insurance.
After all items are received, your request will be reviewed. You will be notified in writing within 30 days of our determination. Please disregard any bills until you have received the decision.

Approval will be valid for all services to include inpatient, emergency room, outpatient and nursing home services rendered for one year from the date of approval. In addition, charity care discounts may be awarded on unpaid medically necessary services up to 120 days prior to the date of service. Requests for discount beyond 120 days will be reviewed on case-by-case basis.

Please be advised that accounts over the 120 day time frame may be eligible for charity care. Therefore, accounts collections may not be eligible for Charity Care and you will still be responsible for payment.

**IMPORTANT - Charity Care Program does not cover the following services:**

- Prescriptions and dental services unless performed in operating room environment (documentation to support medical necessity may be requested)
- Private physician charges, elective non-medically necessary procedures are not covered under Charity Care
- Medicaid client shares, Spend downs
- Private room differentials, guest trays, telephone/television charges
- No fault and Workers Compensation cases are not covered
- Documentation to support medical necessity may be requested.

Please return information to:

Kaleida Health

Charity Care Program

Financial Counseling Services

726 Exchange Street, 3rd Floor

Buffalo, New York 14210

716-859-8979

716 859=8657 - Fax