JOHNSON MEMORIAL HOSPITAL
PATIENT ACCOUNTS DEPARTMENT
BAD DEBT POLICY

Docket #10-029AR
Report 15

STANDARD:

Johnson Memorial Hospital's primary responsibility is to provide the highest quality of medical care to its patients at the lowest cost. In order to meet these requirements, Johnson Memorial Hospital's Bad Debt Policy will provide the cash flow required to operate the institution effectively.

PURPOSE:

The primary responsibility for settlement of the account will rest with the patient.

PROCEDURE:

All patients, capable of doing so, will be required to sign a payment guarantee prior to admission or receipt of services. In any controversy, default, or misrepresentation, the hospital will contact the patient for payment of the bill.

Johnson Memorial Hospital will extend credit on third party benefits assigned to the hospital under proper validation of coverage. Johnson Memorial Hospital will cooperate with all third party payers to the fullest extent in order to facilitate the collection of patient's bills.

These collection policies and procedures apply to all self-pay accounts and accounts with balances such as deductibles and co-insurance.

Final detail bills and insurance claim forms (UB-04, 1500, etc) are produced, at a minimum, four days after discharge (inpatient), date of service (outpatient) and are referred to the appropriate billing section. After review for completeness and correctness, the insurance claim is submitted to the appropriate third party either through electronic claim submission or hard copy submission. In the absence of third party coverage, a statement is sent directly to the patient or guarantor.

Secondary coverage claims are submitted to the appropriate third party once the primary carrier has completed its adjudication of the claim.

Four collection statements are generated for all Self Pay accounts and self pay accounts after all insurances have paid at thirty-day intervals. After the first statement, accounts are outsource to an outside agency for extensive review and follow-up with the patient and/or guarantor.. A fourth and final statement is mailed at 120 days with a collection activity message and requesting an immediate response. Collection activity will be evaluated for final action at 120 days.

After 120 days all accounts deemed uncollectible are then referred to an outside agency and/or attorney for collection.

Report 15

The Director of Patient Accounts must approve the collection agency's or attorney's recommendation to get a judgment lien if the debtor does not settle an outstanding account.

After the agency or attorney exhausts all collection efforts, the uncollectible accounts are returned to the hospital's Billing Department.

Medicare accounts with balances due to co-insurance and /or deductibles will be treated like any self pay outstanding receivables. The collection agency must make reasonable efforts to collect the Medicare co-insurance and/or deductible from the debtor.

Patient's who can demonstrate that payment of their outstanding hospital bill would be a hardship for them to pay may apply for financial assistance.

All applicants must complete the required application and agree to assist hospital staff by obtaining appropriate information required to determine eligibility.

To qualify for full or partial assistance, the patient must meet the following criteria:

Full Assistance: The patient must not be covered by, nor receive services under, a third party insurer or a governmental payor such as Medicare or Medicaid. The applicant must also meet twice the current federal government's published poverty guidelines.

Partial Assistance: The patient must meet three and a half times the federal government's published poverty guidelines.

The Patient Accounts Representative and Supervisor will review all application and make recommendations to the Director of Patient Accounts for patient's eligibility for financial assistance.

JOHNSON MEMORIAL HOSPITAL
PATIENT ACCOUNTS DEPARTMENT
FINANCIAL ASSISTANCE POLICY

free care policy

Record - 15

STANDARD:

Johnson Memorial Hospital recognizes its responsibility to assist patients unable to pay for services rendered.

POLICY:

Johnson Memorial Hospital will provide free or reduced cost medical services to those patients who are uninsured and/or underinsured and whose services are deemed medically necessary.

PROCEDURE:

A. Notification of the availability of Financial Assistance will be posted in the following areas of the Hospital in both English and Spanish:
   1. Admitting
   2. Emergency Department
   3. Patient Account Department
   4. Social Service

B. All Self Pay patients will be given, at time of registration, the Notice of Uninsured Qualifications. (In English and Spanish)
   1. The Notice will identify the criteria for qualifying for a reduction in billed charges
   2. The Notice will identify the number to call to obtain applications for reduced charges.

C. All requests for assistance will be forwarded an application form with instructions for completion.

D. Completed applications will be reviewed to determine patient's eligibility for assistance.

E. Criteria for determining eligibility and the amount of financial assistance for which the patient is eligible will include the following factors as well as others:
   1. Individual and/or family income - The hospital will recognize standards for determination of poverty with consideration of family size and other pertinent factors. Individual or family income generally is not the exclusive criteria for determining the appropriate amount of financial assistance.

   2. Individual or family net worth – The hospital will consider all liquid and non-liquid assets owned, less liabilities and claims against assets. Eligibility for Medicaid will also be considered.

3. Employment status – The hospital will consider the likelihood of future earnings sufficient to meet their medical related obligation within a reasonable period of time.

4. Implications of family size in addition to adequacy of individual or family income will be considered.

5. Other financial obligations including living expenses and other items of a reasonable and necessary nature will be considered.

6. The amount and frequency of bills for healthcare services will be considered in relation to all the other factors outlined above. While eligibility relates to meeting criteria at the time service is rendered, the history of service and the need for future service may be considered. A separate determination of the amount of financial assistance for which a patient is eligible is made on such occasion of service, or regular confirmation of eligibility is made during extended programs of service.

7. The appropriate form and amount of financial assistance is determined in relation to amounts due after applying all other resources. Criteria may be more detailed and call for more specific evidence of eligibility for large amounts than for small amounts.

F. A request for financial assistance can be made at any time during the collection process. The request may be made by or "on behalf" of an individual seeking services from our hospital. This request can be made before or after services are received.

1 Request received after an account has been turned over to an external collection agency and/or attorney, will be placed on hold with the external party pending determination on the patient's eligibility for assistance.

a. Accounts requesting assistance will be given 30 days to submit completed forms or make payment.
b. If payment, arrangement for payment, or completed financial assistance forms is not received within 30 days, the account will be taken off hold and the external agency for collection will resume collection.

G. Application:

1 Prior to consideration for Financial Assistance all other payment avenues must be exhausted to include patient's application for state assistance if applicable.

2 The patient's account must be in a Self Pay billing status and/or Bad Debt status.

Report 15

3 A Financial Assistance application (see attached) must be completed.

4 Information obtained on the Financial Assistance form is reviewed for accuracy.

5 Comment on the account that a Financial Assistance application has been received.

6 Hold all statements pending determination.

7 Applicant's gross income will be compared to national poverty guidelines to confirm patient falls within established criteria.

8 Next, compare patient's net income to poverty guidelines.

9 Notice of action, approval and /or denial will be sent to the patient.

10 Acknowledgments of approved applications will identify the amount of financial assistance approved and how the balance may be paid.

11 Income guidelines and financial assistance awarded:

400% of Poverty Guidelines	30% assistance
300% of Poverty Guidelines	50% assistance'
250% of Poverty Guidelines	75% assistance
200% of Poverty Guidelines	100% assistance

12 Financial Assistance granted: Notification will be sent out within two weeks of receipt of completed application indicating if financial assistance has been granted and for what amount. If assistance is denied, an explanation of the reason for our determination is submitted.

13 All applications for assistance under Section 19a-673 of the CT General Statues will be logged and reported for reporting to finance.

Examples of income for purposes of determining financial eligibility for this uncompensated services program, includes the following:

- Annual cash receipts before taxes from all sources
- Money wages and salaries before any deductions
- Net receipts from non-farm self employment (receipts from a person's own unincorporated business, professions enterprise, or partnership, after deductions for business expenses)
- Net receipts from farm self employment (receipts from a farm one operates as an owner, renter or sharecropper, after deductions for farm operating expenses)
- Regular payments from social security, railroad retirement, unemployment compensation, strike benefits from union funds, worker's compensation, veteran's payments, public assistance, (including Aid to Families with Dependant Children or Temporary Assistance for Needy Families, Supplemental Security Income, and non Federally Funded General Assistance or General Relief money payments)
- Training stipends
- Alimony
- Child support
- Military family allotments or other support from an absent family member and/or Military Retirement Pensions
- Pensions, Annuities or Insurance payments
- Interest Income
- Rent / Royalties income
- Net Gambling or lottery winnings

Income NOT included in Determining Income Levels:

- Capital Gains
- Assets drawn down as withdrawals from a bank
- Sale of a property (house or car)
- Tax refund
- Gifts
- Loans
- Lump-sum inheritances
- One Time insurance payments
- One time compensation for an injury
- Non cash benefits such as food stamps, school lunches and housing assistance programs.

Report 15

Johnson Memorial Hospital

Patient Accounting Department
201 Chestnut Hill Road
Stafford Springs, CT 06076-4005

Financial Assistance Application

Date Completed: _____

Patient's First Name: _____ Middle Initial: _____ Last Name: _____

Street Address: _____ Apt No.: _____ P.O. Box: _____

City/Town: _____ State: _____ Zip Code: _____ Phone #: _____

Number of Dependents (including spouse) in household: _____ Total Dependents under 18 years old: _____

Income verification is required for all applicants in adherence to the JMH program guidelines listed below. In order for your financial assistance application to be processed, you must provide copies of the following documents as applicable to your 2007 & 2008 income:

- Copy of determination letter from Department of Social Services (**mandatory**).
- Four recent employer pay stubs for yourself and any dependents. Please indicate periods of unemployment.
- Copy of 2007 1040-tax form.
- Proof of alimony, child support, and/or divorce decree.
- Proof of estate, dividends, allotments, tips, social security, retirement pension slips, workers compensation or strike benefits, net winning Income, royalties, annuity income, welfare benefits or general assistance benefits.
- If self-employed, receipts from unincorporated business, professional enterprise, or partnership after deductions for business expenses (use business tax from previous calendar year). Include schedule K-1 (1120).
- If these charges occurred under part of a third party liability suit, please disclose this information.
- If none of the above proof-of-income applies, please provide a detailed letter explaining the means of support for you, your family or household unit.

INCOME

PATIENT'S EMPLOYER: _____ WEEKLY INCOME BEFORE TAX: $ _____

SPOUSE'S EMPLOYER: _____ WEEKLY INCOME BEFORE TAX: $ _____

OTHER MONTHLY INCOME:

SOCIAL SECURITY..... $ _____

PENSION PLAN..... $ _____

OTHER (SPECIFY): _____ $ _____

TOTAL OTHER INCOME $ _____

The above statements are true and accurate. I understand that financial assistance is available only after all other sources of third party reimbursement have been exhausted. I agree to cooperate and follow through with applications for state assistance as well as any other third party payers as requested by your office. This application is subject to approval.

Report 15

Applicant Signature:_____ Date:_____

Application taken by:_____ Status: Approved _____ Denied _____

Reason for Denial: _____ Date:_____ Signature: _____