Hospital of Central Connecticut

Docket Number 11-015AR

Uncompensated Care Policies and Procedures

FY 2011 Annual Reporting

Bad Debt Guidelines for Free Bed and RCC

Policy Account requirements prior to transfer to Bad Debt.

Impact (s) Placement of accounts in Bad Debt location.

Date October 1, 2006

Item	Policy
1	**INSURED** PATIENT, APPLICATION FOR **FREE BED** PROGRAM • Denied by hospital Free Bed does not meet the Department Health and Human Services (DHHS) income criteria (over income). Follow hospital guidelines for turn over of patient balance after insurance. The Self Pay Financial Class is (SA). • Denied by hospital Free Bed Fund does not meet eligibility criteria (dates of service prior to 10/01/2006). Follow hospital guidelines for turn over of patient balance after insurance. (SA) • Approved by hospital Free Bed Fund meets (DHHS) income criteria and is less than 100% discount. Follow hospital guidelines for turn over of patient balance after Free Bed allowance. (SA)
2	**NO INSURANCE** PATIENT, APPLICATION FOR **RCC** AND **FREE BED** PROGRAMS • Denied for RCC, the patient did not meet the definition of "uninsured patient" as defined in Connecticut General Statutes Section 19a-673(a) (4) and is over income. Denied for Free Bed Program does not meet the (DHHS) income criteria (over income). Follow hospital guidelines for turn over of patient balance. (SA) • Denied for RCC, the patient did not meet the definition of "uninsured patient" as defined in Connecticut General Statutes Section 19a-673(a) (4) and is over income. Approved for Free Bed Program does meet the (DHHS) income criteria and is less than

	100% discount. Follow hospital guidelines for turn over of patient balance. (SA)
3	**UNINSURED** PATIENT, APPLICATION FOR **RCC** AND **FREE BED** PROGRAMS. • Approved for RCC (partial discount). Approved for Free Bed Program (within eligibility period) and is less than 100% discount. Follow hospital guidelines for turn over of patient balance. The Self Pay Uninsured financial class is (SU). • Approved for RCC (partial discount). Not approved for Free Bed Program (dates of service prior to 10/01/2006). Follow hospital guidelines for turn over of patient balance. (SU)

Sirois, Michelle

From: Cyrul, Joan
Sent: Friday, August 06, 2010 10:32 AM
To: Patient Account Managers; Sirois, Michelle
Subject: FW: HHS Poverty Guidelines for the Remainder of 2010

From: Tanksley, Diane [mailto:Tanksley@chime.org]
Sent: Friday, August 06, 2010 10:09 AM
To: _Patient Account Managers of CHA Acute Care Hospitals; _Reimbursement Representatives Meeting Group
Subject: HHS Poverty Guidelines for the Remainder of 2010

THE HHS POVERTY GUIDELINES FOR THE REMAINDER OF 2010 (August 2010)

[*Federal Register* Notice, August 3, 2010 — Full text]

[Prior Poverty Guidelines and *Federal Register* References Since 1982]

[Frequently Asked Questions (FAQs)]

[Further Resources on Poverty Measurement, Poverty Lines, and Their History]

[Computations for the 2010 Poverty Guidelines]

Legislation enacted in late 2009 and early 2010 prohibited publication of 2010 poverty guidelines before May 31, 2010, and required that the 2009 poverty guidelines remain in effect until publication of updated guidelines. Legislation to further delay publication of the 2010 guidelines did not pass. The procedure for updating the 2010 guidelines was modified to take into account the Consumer Price Index (CPI-U) for the period for which their publication was delayed. As a result, the poverty guideline figures for the remainder of 2010 — given below — were the same as the 2009 poverty guideline figures.

There are two slightly different versions of the federal poverty measure:

- The poverty thresholds, and
- The poverty guidelines.

The **poverty thresholds** are the original version of the federal poverty measure. They are updated each year by the **Census Bureau** (although they were originally developed by Mollie Orshansky of the Social Security Administration). The thresholds are used mainly for **statistical** purposes — for instance, preparing estimates of the number of Americans in poverty each year. (In other words, all official poverty population figures are calculated using the poverty thresholds, not the guidelines.) Poverty thresholds since 1973 (and for selected earlier years) and weighted average poverty thresholds since 1959 are available on the Census Bureau's Web site. For an example of how the Census Bureau applies the thresholds to a family's income to determine its poverty status, see "How the Census Bureau Measures Poverty" on the Census Bureau's web site.

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the *Federal Register* by the **Department of Health and Human Services** (HHS). The guidelines are a simplification of the poverty thresholds for use for **administrative** purposes — for instance, determining financial eligibility for certain federal programs. The *Federal Register* notice of the poverty guidelines for the remainder of 2010 is available.

The poverty guidelines are sometimes loosely referred to as the "federal poverty level" (FPL), but that phrase is ambiguous and should be avoided, especially in situations (e.g., legislative or administrative) where precision is important.

Key differences between poverty thresholds and poverty guidelines are outlined in a table under Frequently Asked Questions (FAQs). See also the discussion of this topic on the Institute for Research on Poverty's web site.

NOTE: The poverty guideline figures below are NOT the figures the Census Bureau uses to calculate the number of poor persons.
The figures that the Census Bureau uses are the poverty thresholds.

The 2010 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family	**Poverty guideline**
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For families with more than 8 persons, add $3,740 for each additional person.	

2010 Poverty Guidelines for Alaska	
Persons in family	**Poverty guideline**
1	$13,530
2	18,210
3	22,890
4	27,570
5	32,250
6	36,930
7	41,610
8	46,290

For families with more than 8 persons, add $4,680 for each additional person.

2010 Poverty Guidelines for Hawaii	
Persons in family	**Poverty guideline**
1	$12,460
2	16,760
3	21,060
4	25,360
5	29,660
6	33,960
7	38,260
8	42,560
For families with more than 8 persons, add $4,300 for each additional person.	

SOURCE: *Federal Register*, Vol. 75, No. 148, August 3, 2010, pp. 45628–45629

The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. Note that the poverty thresholds — the original version of the poverty measure — have never had separate figures for Alaska and Hawaii. The poverty guidelines are not defined for Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, the Republic of the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, and Palau. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office which administers the program is responsible for deciding whether to use the contiguous-states-and-D.C. guidelines for those jurisdictions or to follow some other procedure.

The poverty guidelines apply to both aged and non-aged units. The guidelines have never had an aged/non-aged distinction; only the Census Bureau (statistical) poverty thresholds have separate figures for aged and non-aged one-person and two-person units.

Programs using the guidelines (or percentage multiples of the guidelines — for instance, 125 percent or 185 percent of the guidelines) in determining eligibility include Head Start, the Food Stamp Program, the National School Lunch Program, the Low-Income Home Energy Assistance Program, and the Children's Health Insurance Program. Note that in general, cash public assistance programs (Temporary Assistance for Needy Families and Supplemental Security Income) do NOT use the poverty guidelines in determining eligibility. The Earned Income Tax Credit program also does NOT use the poverty guidelines to determine eligibility. For a more detailed list of programs that do and don't use the guidelines, see the Frequently Asked Questions (FAQs).

The computations for the poverty guidelines for the remainder of 2010 are available.

The poverty guidelines may be formally referenced as "the poverty guidelines updated periodically in the *Federal Register* by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)."

Diane M. Tanksley
Assistant Director, Finance
Connecticut Hospital Association
Phone: (203) 294-7284
Fax: (203) 265-9910
tanksley@chime.org

DHHS Poverty Guidelines

The Hospital of Central Connecticut NB and BM campuses

annual income:

family size	100%		90%		75%		60%		45%		30%		15%	
1	10,830	16,245	16,246	19,008	19,009	22,240	22,241	26,022	26,023	30,447	30,448	35,625	35,626	41,682
2	14,570	21,855	21,856	25,572	25,573	29,920	29,921	35,007	35,008	40,960	40,961	47,924	47,925	56,072
3	18,310	27,465	27,466	32,135	32,136	37,599	37,600	43,992	43,993	51,472	51,473	60,224	60,225	70,463
4	22,050	33,075	33,076	38,699	38,700	45,279	45,280	52,977	52,978	61,985	61,986	72,523	72,524	84,854
5	25,790	38,685	38,686	45,263	45,264	52,958	52,959	61,963	61,964	72,497	72,498	84,823	84,824	99,244
6	29,530	44,295	44,296	51,826	51,827	60,638	60,639	70,948	70,949	83,010	83,011	97,123	97,124	113,635
7	33,270	49,905	49,906	58,390	58,391	68,317	68,318	79,933	79,934	93,522	93,523	109,422	109,423	128,025
8	37,010	55,515	55,516	64,954	64,955	75,997	75,998	88,918	88,919	104,035	104,036	121,722	121,723	142,416

weekly income:

family size	100%		90%		75%		60%		45%		30%		15%	
1	208	312	313	366	367	428	429	500	501	586	587	685	686	802
2	280	420	421	492	493	575	576	673	674	788	789	922	923	1,078
3	352	528	529	618	619	723	724	846	847	990	991	1,158	1,159	1,355
4	424	636	637	744	745	871	872	1,019	1,020	1,192	1,193	1,395	1,396	1,632
5	496	744	745	870	871	1,018	1,019	1,192	1,193	1,394	1,395	1,631	1,632	1,909
6	568	852	853	997	998	1,166	1,167	1,364	1,365	1,596	1,597	1,868	1,869	2,185
7	640	960	961	1,123	1,124	1,314	1,315	1,537	1,538	1,799	1,800	2,104	2,105	2,462
8	712	1,068	1,069	1,249	1,250	1,461	1,462	1,710	1,711	2,001	2,002	2,341	2,342	2,739

* For family units with more than 8 members, add $3,740 for each additional member.

2011

The Hospital of Central Connecticut
100 Grand Street
New Britain, Connecticut 06050

FREE BED FUND SUMMARY

A "Free Bed Fund" has been established from gifts of money or stock donated to The Hospital of Central Connecticut to help pay for the care of certain needy patients. The Fund is used to pay for the cost (partially or fully) for Inpatient, Outpatient and Emergency services rendered at The Hospital of Central Connecticut. The following is required:

- Applied for financial assistance programs within the State you reside and been denied eligibility. **Proof of Denial from the Department of Social Services is Required.**
- Have a household income at or below 250% of the Federal Poverty Income Guidelines. **Proof of Income and/or Assets is required.**

On all completed applications The Hospital of Central Connecticut will provide a written notification of acceptance or rejection (and the reason why) for Funds within two weeks. If a patient has been rejected for Free Bed Funds, they may reapply if the reason for rejection has changed.

To be eligible for Free Bed Fund, applicants (parents or guardians, if the patient is a minor) must:

- Present a photo I.D., such as a valid CT driver's license, passport or immigration identification card (Green Card);
- Attach letter of approval or denial from the State of Connecticut Department of Social Services for medical assistance or similar program if not a resident of Connecticut;
- Attach proof of income and/or assets with the application.

Completed documents must be returned within **14 days of state response or all eligible accounts may not be considered.**

Mail to:

Patient Financial Services
The Hospital of Central Connecticut
100 Grand St.
New Britain, CT 06050

or

Deliver to:

Patient Financial Services
The Hospital of Central Connecticut
389 John Downey Drive
New Britain, CT 06051

All incomplete applications received by the Patient Financial Representative, will be returned to the applicant within three weeks of receipt. The returned application will include a detailed cover letter defining why the application was returned. The applicant will have 30 days to return all requested information. If you should have any questions in regards to this application, please don't hesitate to contact a Patient Financial Representative at (860) 224-5181.

Revised 01/01/08, 01/23/08, 04/22/09, 01-01-11

THE HOSPITAL OF CENTRAL CONNECTICUT
New Britain, Connecticut

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name: _____ Date of application: _____

Address: _____ Medical Record #: _____

_____ HCC Rep. Int.: _____

Applied for Financial Assistance with programs within the State you reside for medical assistance (Yes/No) _____

If *YES*, please include copy of the denial letter.

If *NO*, as mentioned on page one, we cannot process your Free Bed application unless you have completed the application process for medical assistance within the State you reside and have been denied coverage.

Please list any health insurance or accident coverage (liability, auto or workers compensation) that you have, which may cover your outstanding balances:

Insurance Company name: _____

ID/Policy number: _____

Insurance Telephone Number: _____

I understand it is my responsibility to provide all requested information to assist The Hospital of Central Connecticut in making an eligibility determination.

_____ _____

Patient Signature or Authorized Agent Date

PATIENT NAME

NAME: _____ DATE OF BIRTH: _____

WWII Veteran? YES ___ NO ___

GUARANTOR INFORMATION

RELATIONSHIP TO PATIENT: ( ) SELF ( ) PARENT

NAME: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ WORK PHONE #: _____

MARITAL STATUS: _____ # DEPENDENTS: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

_____

INCOME (PLEASE NOTE WEEKLY/ MONTHLY/ ANNUALLY)

GROSS SALARY: _____

SOCIAL SECURITY INCOME: _____ CHILD SUPPORT: _____

SOC SEC DISABILITY: _____ ALIMONY: _____

PENSION: _____ STOCKS / BONDS _____

WORKERS COMP: _____ UNEMPLOYMENT: _____

RENTAL PROPERTY INCOME: _____ PUBLIC ASSISTANCE/ FOOD STAMPS: _____

TRUST: _____

OTHER (type & source): _____

PARENT OF PATIENT IF PATIENT IS A MINOR, OR PATIENT'S SPOUSE

NAME: _____

DATE OF BIRTH: _____ WORK PHONE #: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

WWII Veteran? YES ___ NO ___

INCOME (PLEASE NOTE WEEKLY/ MONTHLY/ ANNUALLY)

GROSS SALARY: _____

SOCIAL SECURITY INCOME: _____ CHILD SUPPORT: _____

SOC SEC DISABILITY: _____ ALIMONY: _____

PENSION: _____ STOCKS / BONDS _____

WORKERS COMP: _____ UNEMPLOYMENT: _____

RENTAL PROPERTY INCOME: _____ PUBLIC ASSISTANCE/ FOOD STAMPS: _____

TRUST: _____

OTHER (type & source): _____

DEPENDENT INFORMATION IF UNDER 18

CHILD'S NAME	SS#	DATE OF BIRTH	INCOME (type & source)	CHILD LIVES WITH WHOM

SAVINGS and ASSETS

SAVINGS ACCOUNT BALANCE: _____CHECKING ACCOUNT BALANCE: _____

RETIREMENT ACCOUNT (IRA): _____

403B/ 401K: _____

ANNUITY: _____

TRUST: _____

OTHER: _____

MONTHLY EXPENSES

RENT AMOUNT: _____

MORTGAGE AMOUNT: _____

I certify that the information provided is true. I also authorize The Hospital of Central Connecticut and/or its agents to investigate the references and statements or other data obtained from me or from any other person pertaining to my credit and financial responsibility.

Date of Signing: _____ By: _____
(Patient or Authorized Agent)

_____
(Relationship to Patient)

Witness: _____

If someone helped the applicant complete this form, this person must sign also.

_____

Helper's Signature Relationship (if any) Date

The Hospital of Central Connecticut
100 Grand Street
New Britain, Connecticut 06050

ZASADY FUNDUSZU FREE BED FUNDS

Fundusz Free Bed Funds służy do finansowania opieki medycznej niektórych pacjentów znajdujących się w potrzebie. Jest on finansowany z darów pieniężnych lub w postaci papierów wartościowych na rzecz szpitala Central Connecticut. Fundusz pokrywa (całkowicie lub częściowo) koszty usług hospitalizacji, ambulatoryjnych oraz ratunkowych świadczonych w szpitalu Central Connecticut. Warunki są następujące:

- Złożenie wniosku o pomoc finansową w stanie zamieszkania i odmowa jej przyznania. **Wymagane jest świadectwo odmowy.**

- Całkowity dochód gospodarstwa domowego na poziomie 250% federalnego minimum ubóstwa lub poniżej. **Wymagane jest świadectwo dochodów i/lub majątku.**

Stwierdzenie uprawnienia do funduszu Free Bed Funds jest ważne przez 6 (sześć) miesięcy — 3 (trzy) miesiące w przód i 3 (trzy) miesiące wstecz od daty złożenia wniosku; jeśli pacjent chce dłużej korzystać z pomocy, musi złożyć wniosek ponownie. Szpital Central Connecticut rozpatruje wszystkie złożone wnioski w ciągu dwóch tygodni, informując na piśmie o ich przyjęciu lub odrzuceniu (z podaniem powodu). Jeśli wniosek pacjenta o dofinansowanie z funduszu Free Bed Funds został odrzucony, może on złożyć go ponownie, o ile zmieniła się sytuacja będąca przyczyną jego odrzucenia.

Aby uzyskać dofinansowanie z funduszu Free Bed Fund, wnioskodawcy (lub rodzice albo opiekunowie, jeśli pacjent jest niepełnoletni) muszą:

- okazać dowód tożsamości ze zdjęciem, jak np. prawo jazdy wydane w stanie Connecticut, paszport lub karta stałego pobytu (zielona karta);
- dołączyć pisemną odmowę pokrycia kosztów leczenia przez Wydział Opieki Społecznej stanu Connecticut lub pisemną odmowę przyznania innej pomocy finansowej w przypadku zamieszkania poza stanem Connecticut;
- dołączyć do wniosku świadectwo dochodów i/lub majątku.

Wypełnione dokumenty muszą zostać zwrócone w ciągu 14 dni od ich otrzymania.

Adres pocztowy:

Patient Financial Services
The Hospital of Central Connecticut
100 Grand St.
New Britain, CT 06050

lub

Doręczenie osobiste:

Patient Financial Services
The Hospital of Central Connecticut
389 John Downey Drive
New Britain CT 06051

Wszystkie niepełne wnioski otrzymane przez dział relacji finansowych z pacjentami będą zwracane wnioskodawcy w ciągu dwóch tygodni od ich otrzymania. Do zwróconego wniosku będzie dołączone pismo szczegółowo objaśniające powód zwrotu wniosku. Wnioskodawca będzie miał 30 dni na zwrot wszystkich wymaganych informacji. Odpowiedzi na wszelkie pytania dotyczące tego wniosku udziela dział relacji finansowych z pacjentami pod numerem (860) 224-5181.

Modyfikowano 10/19/2007, 01/24/2008, 01-01-11

THE HOSPITAL OF CENTRAL CONNECTICUT
New Britain, Connecticut

WNIOSEK O POMOC FINANSOWĄ

Nazwisko pacjenta: _____ Data wniosku: _____

Adres: _____ Nr karty pacjenta:_____

_____ Rep. Int. _____

Składałam/składałem wniosek o pomoc finansową na pokrycie kosztów leczenia w moim stanie zamieszkania (tak/nie) _____

Jeśli *TAK*, prosimy dołączyć kopię pisma odmownego.

Jeśli *NIE*, zgodnie z warunkami podanymi na stronie pierwszej, nie możemy rozpatrzyć wniosku o dofinansowanie z funduszu Free Bed Funds, dopóki Pani/Pan nie skończy się starać o pokrycie kosztów leczenia w swoim stanie zamieszkania i nie otrzyma odmowy.

Wymienić wszystkie posiadane ubezpieczenia zdrowotne lub wypadkowe (OC, samochodowe lub pracownicze), które mogłyby pokryć zaległe zobowiązania:

Nazwa firmy ubezpieczeniowej: _____

Numer polisy: _____

Numer telefonu ubezpieczenia: _____

Wiem, że mam obowiązek udostępnić wszystkie wymagane informacje, aby pomóc szpitalowi Central Connecticut podjąć decyzję, czy przyznać mi pomoc finansową.

_____ _____

Podpis pacjenta lub pełnomocnika Data

INFORMACJE O PACJENCIE

IMIĘ I NAZWISKO: _____ DATA URODZENIA: _____

Weteran II Wojny Światowej? TAK ___ NIE ___

INFORMACJE O PORĘCZYCIELU

POKREWIEŃSTWO Z PACJENTEM: ( ) TA SAMA OSOBA ( ) RODZIC ( ) MĄŻ/ŻONA

IMIĘ I NAZWISKO: _____ DATA URODZENIA: _____

ADRES ZAMIESZKANIA: _____

MIEJSCOWOŚĆ: _____STAN: _____ KOD POCZTOWY: _____

TELEFON DOMOWY: _____ TELEFON DO PRACY: _____

STAN CYWILNY: _____LICZBA OSÓB NA UTRZYMANIU: _____

NAZWA PRACODAWCY: _____

ADRES PRACODAWCY: _____

_____

DOCHÓD (PROSZĘ ZAZNACZYĆ: TYGODNIOWY / MIESIĘCZNY / ROCZNY)

PENSJA BRUTTO: _____

UBEZPIECZENIE SPOŁECZNE: _____ZASIŁEK NA DZIECKO: _____

RENTA CHOROBOWA: _____ ALIMENTY: _____

EMERYTURA: _____ AKCJE / OBLIGACJE _____

ODSZKODOWANIE PRACOWNICZE: _____ ZASIŁEK DLA BEZROBOTNYCH: _____

DOCHÓD Z NIERUCHOMOŚCI: ____POMOC SPOŁECZNA/ KUPONY NA ŻYWNOŚĆ: ____

FUNDUSZ POWIERNICZY: _____

INNY (typ i źródło): _____

DRUGA OSOBA DOROSŁA W GOSPODARSTWIE DOMOWYM

IMIĘ I NAZWISKO: _____

DATA URODZENIA: _____ TELEFON DO PRACY: _____

PRACODAWCA _____

ADRES PRACODAWCY: _____

Weteran II Wojny Światowej? TAK ___ NIE ___

DOCHÓD (PROSZĘ ZAZNACZYĆ: TYGODNIOWY / MIESIĘCZNY / ROCZNY)

PENSJA BRUTTO: _____

UBEZPIECZENIE SPOŁECZNE: _____ZASIŁEK NA DZIECKO: _____

RENTA CHOROBOWA: _____ ALIMENTY: _____

EMERYTURA: _____ AKCJE / OBLIGACJE _____

ODSZKODOWANIE PRACOWNICZE: _____ ZASIŁEK DLA BEZROBOTNYCH: _____

DOCHÓD Z NIERUCHOMOŚCI: _____ POMOC SPOŁECZNA/ KUPONY NA ŻYWNOŚĆ: ____

FUNDUSZ POWIERNICZY: _____

INNY (typ i źródło): _____

INFORMACJE O OSOBACH NA UTRZYMANIUPONIŻEJ 18 ROKU ŻYCIA

IMIĘ I NAZWISKO DZIECKA	NUMER UBEZPIECZENIA SPOŁECZNEGO	DATA URODZENIA	DOCHÓD (typ i źródło)	Z KIM MIESZKA DZIECKO

OSZCZĘDNOŚCI i MAJĄTEK

SALDO NA RACHUNKU OSZCZĘDNOŚCIOWYM: __SALDO NA RACHUNKU BIEŻĄCYM: __

KONTO EMERYTALNE (IRA): _____

403B/ 401K: _____

RENTA: _____

FUNDUSZ POWIERNICZY: _____

INNE: _____

MIESIĘCZNE WYDATKI

OPŁATA ZA MIESZKANIE: _____

OPŁATA ZA HIPOTEKĘ: _____

Oświadczam, że podane informacje są prawdziwe. Upoważniam również szpital Central Connecticut i/lub jego przedstawicieli do zbadania dokumentów i deklaracji lub innych danych uzyskanych ode mnie lub od innej dowolnej innej osoby, za którą odpowiadam finansowo i kredytowo.

Data podpisania: _____ _____

(Pacjent lub pełnomocnik)

_____
(Pokrewieństwo z pacjentem)

Świadek: _____

Jeśli ktoś pomagał wnioskodawcy wypełnić ten formularz, również musi się podpisać.

_____

Podpis pomocnika | Pokrewieństwo (jeśli występuje) | Data

The Hospital of Central Connecticut
100 Grand Street
New Britain, Connecticut 06050

RESUMEN DEL FONDO PARA CAMAS GRATUITAS

Se ha creado un "Fondo para camas gratuitas" a partir de las donaciones de dinero o acciones realizadas a The Hospital of Central Connecticut para ayudar a pagar el cuidado de ciertos pacientes que lo necesitan. El Fondo se usa para abonar (parcial o totalmente) el costo de los servicios de internación, ambulatorios y de emergencia prestados por The Hospital of Central Connecticut. Los siguientes requisitos son obligatorios:

- Haber solicitado programas de asistencia financiera del estado en el que reside y que estos hayan sido rechazados. **Se exige prueba del rechazo por parte del Departamento de Servicios Sociales.**
- Contar con un ingreso familiar del 250% o menor del Parámetro Federal de Pobreza. **Se exigen pruebas de ingresos y bienes.**

The Hospital of Central Connecticut enviará una notificación de aceptación o rechazo por escrito (y la razón) respecto de todas las solicitudes completadas para los Fondos dentro de un período de dos semanas. Si a un paciente se le ha rechazado la solicitud de Fondos para camas gratuitas, éste puede solicitarlo nuevamente si la razón para el rechazo ha cambiado.

Para poder acceder al Fondo para camas gratuitas, los solicitantes (padres o tutores, si el paciente es un menor) deben:

- Presentar una identificación con foto, como una licencia de conducir vigente de CT, pasaporte o cédula de identificación inmigratoria (Tarjeta de Residencia);
- Adjuntar la carta de aprobación o rechazo del Departamento de Servicios Sociales del Estado de Connecticut para brindarle asistencia médica o de un programa similar si no es residente de Connecticut;
- Adjuntar prueba de ingresos y bienes junto con la solicitud.

Los documentos completos deben devolverse dentro de los **14 días de recibir la respuesta del estado o todas las cuentas elegibles podrían no ser consideradas**.

Enviar por correo a:

Patient Financial Services
The Hospital of Central Connecticut
100 Grand St.
New Britain, CT 06050

o

Entregar a:

Patient Financial Services
The Hospital of Central Connecticut
389 John Downey Drive
New Britain CT 06051

Todas aquellas solicitudes incompletas recibidas por el Representante Financiero del Paciente serán devueltas al solicitante dentro de las tres semanas de haber sido recibidas. La solicitud devuelta incluirá una carta de presentación detallada explicando por qué la solicitud fue devuelta. El solicitante tendrá 30 días para enviar toda la información solicitada. Si tiene preguntas con respecto a esta solicitud, no dude en contactarse con un Representante Financiero para Pacientes al (860) 224-5181.

THE HOSPITAL OF CENTRAL CONNECTICUT
New Britain, Connecticut

SOLICITUD DE ASISTENCIA FINANCIERA

Nombre del paciente: _____ Fecha de la solicitud: _____

Domicilio: _____ Número de registro médico: _____

_____ Rep. Int. de HCC _____

Ha solicitado Asistencia Financiera de programas provistos por el estado en el que reside para asistencia médica (Sí/No) _____

Si su respuesta es *SÍ*, incluya copia de la carta de rechazo.

Si su respuesta es *NO*, como se mencionó en la página uno, no podemos procesar su solicitud para una cama gratuita a menos que haya completado el proceso de solicitud para asistencia médica del estado en el que reside y se le haya negado cobertura.

Enumere cualquier seguro médico o cobertura por accidentes (responsabilidad, automotor o indemnización laboral) que posea, que puedan pagar sus saldos pendientes:

Nombre de la compañía aseguradora: _____

Identificación/número de la póliza: _____

Número de teléfono de la aseguradora: _____

Comprendo que es mi responsabilidad suministrar toda la información requerida para ayudar a The Hospital of Central Connecticut a determinar mi aptitud.

_____ _____

Firma del paciente o agente autorizado Fecha

INFORMACIÓN DEL PACIENTE

NOMBRE: _____ FECHA DE NACIMIENTO: _____

Veterano de la Segunda Guerra Mundial SÍ ___ NO ___

INFORMACIÓN DEL GARANTE

RELACIÓN CON EL PACIENTE: ( ) MISMA ( ) PADRE

NOMBRE: _____ FECHA DE NACIMIENTO: _____

DOMICILIO: _____

CIUDAD: _____ ESTADO: _____ CÓDIGO POSTAL: _____

N.º DE TELÉFONO PARTICULAR: _____

N.º DE TELÉFONO LABORAL: _____

ESTADO CIVIL: _____ N.º DE DEPENDIENTES: ___

NOMBRE DEL EMPLEADOR: _____

DOMICILIO DEL EMPLEADOR: _____

_____

INGRESOS (POR FAVOR ACLARAR SI SON SEMANALES/MENSUALES/ANUALES)

SALARIO BRUTO: _____

SEGURO SOCIAL: _____ MANUTENCIÓN INFANTIL: _____

SEGURO SOCIAL POR DISCAPACIDAD: _____ PENSIÓN ALIMENTICIA: _____

PENSIÓN: _____ ACCIONES / BONOS _____

INDEMNIZACIÓN LABORAL: _____ POR DESEMPLEO: _____

INGRESOS POR RENTAS DE BIENES INMUEBLES: _____

ASISTENCIA PÚBLICA/CUPONES DE COMIDA: _____

FIDEICOMISO: _____

OTRO (clase y fuente): _____

PADRE DEL PACIENTE SI EL PACIENTE ES UN MENOR, O CÓNYUGE DEL PACIENTE

NOMBRE: _____

FECHA DE NACIMIENTO: _____ N.º DE TELÉFONO LABORAL: _____

EMPLEADOR: _____

DOMICILIO DEL EMPLEADOR: _____

Veterano de la Segunda Guerra Mundial SÍ ___ NO ___

INGRESOS (POR FAVOR ACLARAR SI SON SEMANALES/MENSUALES/ANUALES)

SALARIO BRUTO: _____

SEGURO SOCIAL: _____ MANUTENCIÓN INFANTIL: _____

SEGURO SOCIAL POR DISCAPACIDAD: _____ PENSIÓN ALIMENTICIA: _____

PENSIÓN: _____ ACCIONES / BONOS _____

INDEMNIZACIÓN LABORAL: _____ POR DESEMPLEO: _____

INGRESOS POR RENTAS DE BIENES INMUEBLES: _____

ASISTENCIA PÚBLICA/CUPONES DE COMIDA: _____

FIDEICOMISO: _____

OTRO (clase y fuente): _____

INFORMACIÓN DE DEPENDIENTES SI SON MENORES DE 18 AÑOS

NOMBRE DEL MENOR	N.º DE SS	FECHA DE NACIMIENTO	INGRESO (tipo y fuente)	EL MENOR VIVE CON

AHORROS y BIENES

SALDO DE SU CUENTA DE AHORROS: _____

SALDO DE SU CUENTA CORRIENTE: _____

CUENTA DE JUBILACIÓN (IRA): _____

403B/ 401K: _____

RENTA VITALICIA: _____

FIDEICOMISO: _____

OTRO: _____

GASTOS MENSUALES

MONTO DE LA RENTA: _____

MONTO DE LA HIPOTECA: _____

Certifico que la información provista es verdadera. Asimismo autorizo a The Hospital of Central Connecticut y sus agentes a investigar las referencias y declaraciones o datos obtenidos de mí o de cualquier otra persona con relación a mi crédito y mi responsabilidad financiera.

Fecha de la firma: _____ Por: _____
(Paciente o agente autorizado)

_____
(Relación con el paciente)

Testigo: _____

Si alguien ha ayudado al solicitante a completar este formulario, dicha persona también debe firmar.

_____

Firma del ayudante Relación (si hubiera) Fecha

The Hospital of Central Connecticut
New Britain General Campus
(860) 224-5181

The Hospital of Central Connecticut
Bradley Memorial Campus
(860) 224-5181

FREE BED FUNDS

If you are coping with a personal financial hardship, and are facing significant debts owed to The Hospital of Central Connecticut, "Free Bed Funds" may be available to cover the cost (partially or fully) for inpatient, outpatient and emergency services rendered at the hospital. The following is required:

- Applied for financial assistance programs within the State you reside and been denied eligibility. **Proof of Denial is Required.**
- Have a household income at or below 250% of the Federal Poverty Income Guidelines. **Proof of Income and/or Assets is Required.**

If you meet the above criteria, to obtain a Free Bed application please contact a Patient Financial Representative at (860) 224-5181 and include the following required documentation when returning the application (parents or guardians may complete, if the patient is a minor):

- A photo I.D. such as a valid CT driver's license, passport or immigration identification card (Green Card)
- A letter of denial from the State of Connecticut for medical assistance or similar program if not a resident of Connecticut
- Proof of income and/or assets

You are entitled to reapply for Free Bed Funds if previously rejected.

FREE BED FUNDS

Jeśli borykasz się z prywatnymi trudnościami finansowymi i masz duże zadłużenie wobec szpitala Central Connecticut, koszty usług hospitalizacji, ambulatoryjnych oraz ratunkowych świadczonych przez szpital mogą zostać pokryte (całkowicie lub częściowo) z funduszu Free Bed Funds. Warunki są następujące:

- Złożenie wniosku o pomoc finansową w stanie zamieszkania i odmowa jej przyznania. **Wymagane jest świadectwo odmowy.**
- Całkowity dochód gospodarstwa domowego na poziomie 250% federalnego minimum ubóstwa lub poniżej. **Wymagane jest świadectwo dochodów i/lub majątku.**

Jeśli spełniasz te kryteria, zadzwoń do działu relacji finansowych z pacjentami pod numer (860) 224-5181, aby otrzymać wniosek o dofinansowanie z funduszu Free Bed Fund i dołącz następujące dokumenty do wypełnionego wniosku (jeśli pacjent jest niepełnoletni, mogą go za niego wypełnić rodzice lub opiekunowie):

- dowód tożsamości ze zdjęciem, jak np. prawo jazdy wydane w stanie Connecticut, paszport lub karta stałego pobytu (zielona karta);
- pisemną odmowę pokrycia kosztów leczenia przez stan Connecticut lub pisemną odmowę przyznania innej pomocy finansowej w przypadku zamieszkania poza stanem Connecticut;
- świadectwo dochodów i/lub majątku.

Możliwe jest ponowne składanie wniosku o dofinansowanie z funduszu Free Bed Funds w przypadku jego wcześniejszego odrzucenia.

FONDOS PARA CAMAS GRATUITAS

Si usted se encuentra enfrentando una dificultad financiera, y tiene grandes deudas con The Hospital of Central Connecticut, los "Fondos para camas gratuitas" pueden estar disponibles para cubrir (parcial o totalmente) el costo para servicios de internación, ambulatorios y de emergencia brindados en el hospital. Los siguientes requisitos son obligatorios:

- Haber solicitado programas de asistencia financiera del estado en el que reside y que estos hayan sido rechazados. **Se exige prueba del rechazo.**
- Contar con un ingreso familiar del 250% o menor del Parámetro Federal de Pobreza. **Se exigen pruebas de ingresos y bienes.**

Si cumple con los criterios mencionados, contáctese con un Representante Financiero para Pacientes para obtener una solicitud para camas gratuitas al (860) 224-5181 e incluya la siguiente documentación exigida cuando devuelva la solicitud (padres o tutores pueden completarla, si el paciente es menor de edad):

- Una identificación con foto, como una licencia de conducir vigente de CT, pasaporte o cédula de identificación inmigratoria (Tarjeta de Residencia);
- Una carta de rechazo del Estado de Connecticut para brindarle asistencia médica o de un programa similar si no es residente de Connecticut;
- Prueba de ingresos y bienes

Tiene derecho a solicitar nuevamente los Fondos para camas gratuitas si su solicitud ha sido rechazada previamente.

Revised 10-01-06, 12/06/07

Financial Assistance for Non-Regulatory Patients

Overview Hospital guidelines for Non-Regulatory Patients that do not want to go through the application process for our Free Bed/Reduced Care Program.

Impact (s) Receivables

Item	Policy
1	Financial Assistance is available for all non-regulatory patients that choose not to go through the application process for Free Bed/Reduced Care, as in the "Public Act No. 03-266". The Patient Accounts representative will discuss payment options if a patient contacts the hospital and requests assistance on their account(s). The Patient Accounts representative will review the patient's outstanding self-pay balances. The agreed upon financial assistance will automatically be applied to the eligible account(s) of $100.00 and over on individual or combined balances. If the patient has more than one account, all balance will be transferred to the newest account, and that new balance will be adjusted in total. The Patient Accounts representative will change the statement cycle back to level one. If the discounted balance is not paid within the normal statement cycles, the account will follow the normal collection process. This help is available to patient accounts with dates 9-30-2011 and prior only.
2	Process to balance transfer and adjust the patients accounts; o Review all self pay balances on patients file o Add all balances; take adjustment off the total; o Note all accounts; o Have accounts transferred to the newest patient's account. o Put the statement cycle back to step one for first notice.

Patient Payment Arrangements

Policy Criteria defining Patient Payment Arrangements for patient's accounts.

Impact (s) Patient Account Receivables

Item	Policy
1	**Patient Payment Guidelines:** The guidelines below define the amount and terms that the HOCC can accept as a payment plan from the patient. The balance range is for all accounts owed by the patient NOT at a Collection Agency. Balance Range: — Term: $10.00-$249.99 — No Arrangements $250.00-$500.00 — 6 Months $500.01-$2400.00 — 12 Months $2400.01< — Review for agency budget payers
2	**Canceling a Patient Payment Plan:** If the patient misses an installment of their payment plan and can not make the payment up in the next month's statement, the system will prelist the account for collection. Otherwise, the patient may pay their balance in full to avoid collection action. The patient or guarantor also may call to change their payment plan, so long as it is within our guidelines.
3	**Patient Unable to make Payment Plan per Policy:** When patient/guarantor contacts the customer service department and informs them of being unable to make payment on their accounts per policy guidelines, or do a agency budget plan, we are responsible to inform the patient of potential state and hospital assistance available to cover the cost (partially or fully) for Inpatient, Outpatient and Emergency Services rendered at the hospital. (Refer to Free Bed Policy or Summary for detail requirements)

Bad Debt Guidelines and returns policy

Overview Insures that accounts are appropriately handled for transfer to Bad Debt.

Policy Account requirements prior to transfer to Bad Debt.

Impact (s) The placement of accounts in Bad Debt location.

Seq#	Policy
1	The Pre-List Selection Report (FFR300) is produced during the last week of the month to identify all accounts eligible for transfer to Bad Debt during midnight processing on the last day of the month. Accounts are selected based on the following criteria: • Balance is patient's responsibility • Payment in full has not been received during the 3 statement cycle (approx. 90 days) • Account balance is greater than $14.99. (If the patient's responsible balance of an account is less than $15.00 and unpaid, the HBOC Star financial system will post an allowance to the account to bring the balance to $0.00. The system applies that allowance at the interval when a patient's 2nd statement would be generated and mailed for the balance due between $10.00 and $15.00. The patient does not receive a statement for a balance below $7.00 • Account balance is less than $5,000
2	The Pre-List Selection Report is reviewed by the collection staff during the last week of the month for: • Alternative sources of payment • If patient has made 2 or more consecutive payments on the account and the criteria for a payment plan is met, the payment plan is established. • Guarantor and address are correct. • Correct Bad Debt agency has been selected to process the account.
3	The Pre-List Exception Report (FFR385) is produced during the last week of the month to identify all accounts eligible for transfer to Bad Debt, but have the following exceptions and will not transfer:

	• Account Balance is not completely the patient's responsibility • Account has a credit balance • Account Balance is $5,000 and greater
4	The Pre-List Exception Report is reviewed by collection staff for: • Alternative sources of payment • Potential Free Bed/Charity Care applicant • Resolution of balance transfer problems
5	Accounts with balances $5,000 or greater and do not qualify for items listed in Sequence 4, are provided to the supervisor to be approved for transfer to Bad Debt. Approval is based on the account balance: • $5,000 - $10,000 refer to Vice President of Finance • $10,001 - $25,000 refer to Chief Financial Officer • Over $25,000 refer to Chief Executive Officer After approval, the supervisor manually selects the account for transfer to Bad Debt.
6	The collection agency is responsible to provide the hospitals free bed/charity care summary with each collection notice (PA 3-266). If a patient contacts either the hospital or collection agency to apply for such funds, the collection agency is responsible to stop collection activity until notified by the hospital of the outcome of application. .
7	**Exception to sequence #1**. If a Patient's account has a statement returned by the post office with an invalid address that can not be forwarded, the account is flagged in Star to notify admitting of the incorrect address for future visits and the account is pre-listed for bad debt. The collection staff will select the mail return collection agency in Star for bad debt turnover and the account is placed in Bad Debt the last day of the month.
8	**Exception to sequence #1**. Self-pay admissions that are not collectable through standard practices are referred to an outside agency that acts on our behalf to establish Medicaid eligibility. If they are unsuccessful in establishing Medicaid eligibility and can establish payment arrangements with the patient, they retain the account. These accounts are also placed in Bad Debt on the last day of the month.
9	**Exception to sequence #1**. Patient is expired and there is no estate or other means for payment, the account is adjusted using an uncollectable no estate adjustment.

10	**Exception to sequence #1.** If a patient is homeless or has no known address, the account is adjusted using an uncollectable adjustment.
11	**Exception to sequence #1.** If a patient is "uninsured" with an account balance greater than $10,000 and a cash asset to cover the cost of their bill. This account would be turned over to the collection agency to assist in the recovery of the balance due if attempts to collect made by Patient Accounts are unsuccessful. This turnover may occur prior to 90 days and 3 statements received.
12	**RCC/Free Bed Discount:** Patients who meet the definition of "uninsured" according to PA 3-266 and contact our office for help with their accounts for each account that was approved for help under our program will have their bill reduced to the appropriate amounts. This will be done prior to turnover to Bad Debt. The collection agency will be informed that this patient is uninsured by the Free Bed representative changing the Financial Class to 'SU'. **BAD DEBT RETURNS:** Our collection agency, Medconn, will return accounts worked and found to be: deceased, skipped, bankrupt, on State Welfare, or low balances (under $25.00); all other accounts are worked until they have exhausted all efforts and then returned to THOCC. An electronic email with returned uncollectable accounts is sent by Medconn to THOCC each month. The THOCC cashier interfaces the file and accounts are written off under transaction code 8101 = Non-Paid collection. A report is generated with any discrepancies to be corrected to $0.00.

Free Bed Fund and RCC

Policy Criteria defining the purpose and use of the Free Bed Fund and RCC

Impact (s) Patient Account Receivables with self pay amounts

Date October 1, 2006

Item	Policy
1	**Free Bed Fund:** A "Free Bed Fund" has been established from gifts of money or stock donated to the hospital to help pay for the care of those with financial need. The Fund is used to pay for the cost (partially or fully) for Inpatient, Outpatient and Emergency services rendered at the hospital. The following is required: ➢ Present a photo I.D. such as a valid driver's license, passport or immigration identification card (Green Card) ➢ Patients must have applied for financial assistance programs within the State they reside and have been approved/denied eligibility. **Proof of Approval/Denial is required.** (State Approval may not cover all dates of service in the Free Bed Eligibility period.) ➢ Patients must have a household income at or below 250% of the Federal Poverty Income Guidelines. **Proof of Income is required.** ➢ Patients must complete a Free Bed Fund application. Free Bed Funds have maximum eligibility period of (3) three months forward. The eligibility period is determined by the date of the Free Bed application. Patients must reapply once the determined eligibility period has ended. On all completed applications, the hospital will provide a written notification of acceptance or rejection (and the reason why) for Funds within 10 business days. If a patient has been rejected for Free Bed Funds, he/she may reapply if the reason for rejection has changed.

2	**Free Bed Fund Procedure:** 1. The Admissions, Emergency, Social Services and Patient Accounts departments will have postings of Free Bed Funds availability (English, Polish and Spanish) and where to call to obtain information. 2. An informational handout describing the hospital Free Bed Funds is available in the following areas: • Admission Department • Emergency Department • Social Service Department • Patient Accounts Department This handout will be provided to the responsible party upon request or if it has been identified that the patient has exhibited financial need for assistance with their hospital accounts. 3. The Patient Accounts department will track: • Number of applications distributed • Number of applications approved and funds applied • Number of applications denied and the reason why
3	**Incomplete Free Bed Fund Applications:** All incomplete applications received by the Patient Financial Representative, will be returned to the applicant within 3 weeks of receipt. The returned application will include a detailed cover letter defining why the application was returned. The applicant will have 30 days to return all requested information. After the 30 days, accounts will be removed from guarantor follow up hold and resume collection activity.
4	**Uninsured Patients: (RCC) Public Act No. 03-266** Hospital services that have been provided to an uninsured patient (as described in Public Act No. 03-266) are eligible for a Ratio of Cost to Charge (RCC) Discount established by the Office of Health Care Access (OCHA).

6	**Non-Regulatory Adjustment:** When an application is denied for over income or the adjustment amount is less than 40%, THOCC will give the patient the 40% non-regulatory adjustment for all accounts within the determined eligibility period regardless of balance. The % that was calculated from the application for Free Bed will be applied and the difference in the % will be applied to a non-regulatory allowance up to 40%.
7	**Non-Regulatory Adjustment:** If a patient previously accepted a Non-Regulatory adjustment and now has been approved for Free Bed, reverse the Non-Regulatory adjustment and apply the Free Bed adjustments.
8	**Non-Paid Collection Allowance:** For all Collection Agency(s) returns for uncollectable balances, the balance will be written off using the Non-Paid Collection Allowance which will be applied to Free Bed