MILFORD HOSPITAL
POLICY AND PROCEDURES
FINANCIAL ASSISTANCE

POLICY:
Milford Hospital recognizes its responsibility to those patients unable to pay for services rendered. Limited Financial Assistance is available to meet this recognized need. Milford Hospital follows the guidelines of The Connecticut General Statues 19a-673. These guidelines are clearly stated on the Milford Hospital Financial Assistance Request Form.

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. Billing/Credit Office
4. Social Services

B. All Self-Pay patients will be given at time of registration the Notice of Qualifications. (In English and Spanish)

5. The Notice will identify the criteria for qualifying for a reduction in billed charges
6. The Notice will identify the number to call to obtain applications for reduced charge.

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 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.

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 of frequency of bills for healthcare services will be considered in relation to all other factors outlined above. While eligibility relates to meeting criteria at the same 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. Requests received after an account has been turned over to an external collection agency and/or attorney, will be recalled from the external party pending determination on the patient's eligibility for assistance.

   A. Patient's granted assistance;
      1. Will be given 30 days to make full payment or
      2. Make payment arrangement with Milford Hospital. Such arrangement must be approved by Milford Hospital or
      3. If full payment is not received within 30 days or acceptable payment arrangement has not been made the account may be returned to an external agency for collections.

APPLICATION:

4. Prior to consideration for Financial Assistance all other payment avenues must be exhausted. (Find out if the patient applied for state assistance, insurance, etc.).
5. The patient's account must be in a Self Pay billing status or in a pre-collection status.
6. A Financial Assistance application (see attached) must be completed.

7. Information obtained on the Financial Assistance form is reviewed for accuracy.
8. Comment on the account that a Financial Assistance application has been received.
9. Stop cycle bills pending determination.
10. Applicant's gross income will be compared to national poverty guidelines to confirm patient falls within established guidelines.
11. Next patient's net income compared to poverty guidelines.
12. Notice of action, approval and/or denial will be sent to the patient.
13. Acknowledgements of approved applications will identify the amount of financial assistance approved and how the balance may be paid.
14. Income guidelines and financial assistance awarded:

350% of Poverty Guidelines	25% assistance
300% of Poverty Guidelines	50% assistance
250% of Poverty Guidelines	100% assistance
200% of Poverty Guidelines	100% assistance

15. 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.
16. All applications for assistance under Section 19a-673 of the CT. General Statutes will be logged and forwarded to accounting.

MILFORD HOSPITAL
POLICY AND PROCEDURES
CREDIT & COLLECTION BAD DEBT

Purpose: The primary mission of Milford Hospital is to provide the highest quality medical care to its patients at the lowest cost. An efficient and equitable system must be established that will maximize the collection of patient accounts receivable balances in order to provide the cash flow required to operate Milford Hospital effectively.

PROCEDURE:

These Collection Policies and Procedures apply to all accounts. Collection/follow-up work will be prioritized on the basis of largest balance. All rejected third parties will also be classified as self-pay until such time as further insurance is verified.

The statements and credit letters are computer generated according to the schedules outlined below. Accounts will be transferred to the appropriate billing class whenever payments or rejections are received from third party payers. Specific policies and procedures vary with classification of the account as follows:

A. **Pending Financial Assistance**
During hospitalization, Collection Staff will attempt to explain the SAGA application procedure, and provide the appropriate Department of Social Services address and telephone number.

B. **Non-Contractual and Self-Pay Accounts:**
Follow-up on these cases will be as follows:

Days After Billing	Procedures
45	First statement
75	Second statement
105	Final notice sent to patient
135	Turnover to Collection Agency or Attorney

In addition to the above, scheduled telephone contact will be initiated.

Self-Pay Residual
Residual balances after third party payment/rejection will proceed through the appropriate statements, message, letters and phone calls as follows:

1) The day after all third parties are satisfied (paid or rejected), a statement showing the charges, credits and payments applicable thereto and the

resulting self-pay balance will be produced and mailed to the patient.

2) The account will advance through the non-contractual accounts cycle outlined above.

3) In all cases, the cycle detailed for all accounts can be interrupted by one or more of the following occurrences:
   a) Receipt and verification of third party coverage.
   b) Payment arrangements are agreed to and followed by the patient/guarantor.
   c) Evidence that the account is uncollectible, a history of bad debt accounts, or other legal consideration may result in an expedited referral to an agency or attorney.

C. **General Policies**

1) Several general policies have been established to control the activities in the collection cycle.

2) Whenever possible, arrangements with local banks, credit union or the finance company for loans to the patient should be secured to relieve the hospital from the collection process.

3) Minor balances, under $5.00, should be automatically written off 30 days after discharge if no response is received from the patient.

4) Accounts identified as referrals to agencies or attorneys, and accounts directly written off will be reviewed and approved by the Manager and/or Director of Patient Accounts.

D. **Medicare**

1) At time of pre-registration and/or registration of patient, all registration personnel will verify the patient's Medicare coverage and confirm Medicare as the primary payer.

2) The Medicare MSP questionnaire will be completed via the registration program.

3) *Patients will be notified in writing at the time of registration of Medicare covered services that will not be covered during this episode of care, lack of medical necessity, will be issued an Advance Beneficiary Notice (ABN).*

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