The Hospital of Central Connecticut

MCR: 2012-HOCCT

Docket Number – 12-015AR

Report 15

Financial Assistance Policy

Policy	Criteria defining the purpose and use of the Financial Assistance Policy.
Impact (s)	Patient Account Receivables with self pay amounts
Date	October 1, 2011

Item	Policy
1	**Financial Assistance Policy.** A Financial Assistance Policy 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 Financial Assistance 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. Financial Assistance Policy has a maximum eligibility period of (3) three months forward. The eligibility period is determined by the date of the Financial Assistance 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 5 business days. If a patient has been rejected for Financial Assistance, he/she may reapply if the reason for rejection has changed.

2	**Financial Assistance Procedure:** 1. The Admissions, Emergency, Social Services and Patient Accounts departments will have postings of Financial Assistance Funds availability (English, Polish and Spanish) and where to call to obtain information. 2. An informational handout describing the hospital Financial Assistance Funds is available in the following areas: • Admission Department • Emergency Department • Social Service Department • Patient Accounts Department • THOCC website 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 approved and funds applied • Number of applications denied and the reason why
3	**Incomplete Financial Assistance Applications:** All incomplete applications received by the Patient Financial Representative, will be returned to the applicant within 5 days of receipt. The returned application will include a detailed cover letter defining why the application was returned. The applicant will have 14 days to return all requested information. After the 14 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

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Date October 1, 2011 Effective June 01, 2012

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6	**Search of America** All completed applications will be processed through Search of America for the patient's that have a Social Security number. Search of America validates a patient's income level and provides the Federal Poverty Level for the patient.
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

Hartford Healthcare
Financial Assistance Policy

Update Date: 12/16/2010

Purpose: The purpose of this Policy is to set forth the policy of Hartford Healthcare Corporation (sometimes referred to as the "System") governing the provision of free or discounted Health Care Services to patients who meet the System's criteria for Financial Assistance. Specifically, this Policy will describe: (i) the eligibility criteria for Financial Assistance, and whether such assistance includes free or discounted care; (ii) the basis for calculating amounts charged to patients; (iii) the method for applying for Financial Assistance from the System's Hospitals; (iv) the actions the System may take in the event of non-payment, including collections action and reporting to credit agencies for patients that qualify for Financial Assistance; and (v) the System measures to widely publicize this Policy within the community served by Hartford Healthcare.

Scope: This Policy applies to all Hartford Health facilities Health Care Services regardless of the location at which they are being provided by the System.

Definitions:

"Charges" means for a Health Care Service for a patient who is either Uninsured or Underinsured and who is eligible for Financial Assistance, the average of the System's facility three best negotiated commercial payor rates for the Health Care Services.

"Eligibility Criteria" means the criteria set forth in this Policy to determine whether a patient qualifies for Financial Assistance for the Health Care Services provided by the System's facility.

"EMTALA" means the Emergency Medical Treatment and Labor Act, 42 USC 1395dd, as amended from time to time.

"Family" means pursuant to the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, civil union or adoption. For purposes of this Policy, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

"Family Income" means the following income when calculating Federal Poverty Level Guidelines of liquid assets: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources of income. If a person lives with a Family, Family Income includes the income of all Family members.

"Federal Poverty Level Guidelines" means the federal poverty level guidelines established by the United States Department of Health and Human Services.

"Financial Assistance" means free or discounted Health Care Services provided to persons who, pursuant to the Eligibility Criteria, the Hospital has determined to be unable to pay for all or a portion of the Health Care Services.

"Free Bed Funds" means any gift of money, stock, bonds, financial instruments or other property made by any donor to Hartford Healthcare facilities for the purpose of establishing a fund to provide medical care to an inpatient or outpatient of Hartford Healthcare.

"Health Care Services" means Hartford Healthcare facilities (i) emergency medical services as defined by EMTALA; (ii) services for a condition which, if not promptly treated, will result in adverse change in the health status of the individual; (iii) non-elective services provided in response to life-threatening circumstances in a non-emergency department setting; and (iv) medically necessary services as determined by the System facility on a case-by-case basis at the facility's discretion.

"Medically Indigent" means persons whom the System facility has determined to be unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their Family Income or Family assets even though they have income or assets that otherwise exceed the generally applicable Eligibility Criteria for free or discounted care under the Policy.

"Uninsured" means a patient who has no level of insurance or third party assistance to assist in meeting his or her payment obligations for Health Care Services and is not covered by Medicare, Medicaid or Champus or any other health insurance program of any nation, state, territory or commonwealth, or under any other governmental or privately sponsored health or accident insurance or benefit program including, but not limited to workers' compensation and awards, settlements or judgments arising from claims, suits or proceedings involving motor vehicle accidents or alleged negligence.

"Underinsured" means the patient has some level of insurance or third-party assistance but still has out-of-pocket expenses such as high deductible plans that exceed his or her level of financial resources.

Policy: It is Hartford Healthcare's policy to provide Financial Assistance to all eligible individuals who are Uninsured, Underinsured, ineligible for a government program, or otherwise unable to pay for Health Care Services due to their limited financial resources. It is also the System's policy to provide without discrimination care for emergency medical conditions (as defined by EMTALA) to individuals regardless of their eligibility for Financial Assistance under this Policy or for government assistance.

I. Determining Eligibility.

In determining eligibility for Financial Assistance, it is important that both the System facility and the patient work collaboratively. Specifically, the System facilities

will do its best to apply the Eligibility Criteria in a flexible and reasonable manner and the patient will do its best in responding to Hartford Healthcare requests for information in a timely manner.

1. **Eligibility for Financial Assistance.** Individuals who are Uninsured, Underinsured, ineligible for any government health care benefit program and unable to pay for their Health Care Services may be eligible for Financial Assistance pursuant to this Policy. The granting of Financial Assistance shall be based upon an individualized determination of financial need, and shall not take into account age, gender, race, color, national origin, marital status, social or immigrant status, sexual orientation or religious affiliation.

2. **Process for Determining Eligibility for Financial Assistance.** In connection with determining eligibility for Financial Assistance, the System (i) will require that the patient complete an application for Financial Assistance along with providing other financial information and documentation relevant to making a determination of financial eligibility; (ii) may rely upon publicly available information and resources to determine the financial resources of the patient or a potential guarantor; (iii) may pursue alternative sources of payment from public and private payment benefit programs; (iv) may review the patient's prior payment history; and (v) may consider the patient's receipt of state-funded prescription programs, participation in Women, Infants and Children programs, food stamps, subsidized school lunches, subsidized housing, or other public assistance as presumptive eligibility when there is insufficient information provided by the patient to determine eligibility.

3. **Processing Requests.** Hartford Healthcare will use its best efforts to facilitate the determination process prior to rendering services so long as the determination process does not interfere with the provision of emergency medical services as defined under federal law. However, eligibility determinations can be made at any time during the revenue cycle. During the eligibility determination process, the System facilities will at all times treat the patient or their authorized representative with dignity and respect and in accordance with all state and federal laws.

4. **Financial Assistance Guidelines.** Eligibility criteria for Financial Assistance may include, but is not limited to, such factors as Family size, liquid and non-liquid assets, employment status, financial obligations, amount and frequency of healthcare expense (i.e. Medically Indigent) and other financial resources available to the patient. Family size is determined based upon the number of dependents living in the household. In particular, eligibility for Financial Assistance will be determined in accordance with the following guidelines:

(a) ***Uninsured Patients:***

(i) If Family income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 100% discount against the System facility's Charges for Health Care Services;

(ii) If Family income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 50% discount against the System facility's Charges for Health Care Services;

(iii) Patients may also qualify for Free Bed Funds in accordance with the Hartford Healthcare Free Bed Funds Policy; and

(iv) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

(b) ***Underinsured Patients:***

(i) Payment plans will be extended for any patient liability (including without limitation to amounts due under high deductible plans) identified in a manner consistent with the System's Payment Plan Policy;

(ii) If Family Income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 100% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the Charges for the Health Care Services;

(iii) If Family Income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to 50% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the Charges for the Health Care Services;

(v) Patients may also qualify for Free Bed Funds in accordance with Hartford Healthcare Free Bed Funds Policy; and

(vi) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

(c) ***Medically Indigent****:* Patients will be required to submit a Financial Assistance application along with other supporting documentation, such as medical bills, drug and medical device bills and other evidence relating to high-dollar medical liabilities, so that the Hartford Healthcare System Hardship Committee can determine whether the patient qualifies for Financial Assistance due to the patient's medical expenses and liabilities.

II. Method for Applying for Financial Assistance. Patients may ask any nurse, physician, chaplain, or staff member from Patient Registration, Patient Accounts, Office of Professional Services, Case Coordination, or Social Services about initiating the Financial Assistance application process. Information about applying for Financial Assistance is

also available online at www.hartfordhealthcare.org. Signage and written information regarding how to apply for Financial Assistance will be available in Hartford Healthcare facilitiesl emergency service and patient registration areas. Once a patient or his or her legal representative requests information about Financial Assistance, a Financial Counselor will provide the patient or his or her legal representative with the Financial Assistance application along with a list of the required documents that must be provided to process the application. If the patient or his or her legal representative does not provide the necessary documentation and information required to make a Financial Eligibility determination within fourteen (14) calendar days of the Hartford Healthcare facility's request, the Financial Assistance application will be deemed incomplete and rendered void. However, if an application is deemed complete by the System facility, the System facility will provide to the patient or his or her legal representative a written determination of financial eligibility within five (5) business days. Decisions by the System facilities that the patient does not qualify for Financial Assistance may be appealed by the patient or his or her legal representative within fourteen (14) calendar days of the determination. If the patient or his or her legal representative appeals the determination, the Director of Patient Access will review the determination along with any new information and render a final decision within five (5) business days.

III. Relationship to Hartford Healthcare Collection Practices. In the event a patient fails to qualify for Financial Assistance or fails to pay their portion of discounted Charges pursuant to this Policy, and the patient does not pay timely their obligations to Hartford Healthcare, the System reserves the right to institute and pursue collection actions and to pursue any remedies available at law or in equity, including but not limited to, imposing wage garnishments or filing and foreclosing on liens on primary residences or other assets, instituting and prosecuting legal actions and reporting the matter to one or more credit rating agencies. For those patients who qualify for Financial Assistance and who, in the System's sole determination, are cooperating in good faith to resolve the System's outstanding accounts, the System facilities may offer extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences, will not send unpaid bills to outside collection agencies and will cease all collection efforts.

IV. Publication and Education. Hartford Healthcare facilities will disseminate information about its Financial Assistance Policy as follows: (i) provide signage regarding this Policy and written summary information describing the Policy along with financial assistance contact information in the Emergency Department, Labor and Delivery areas and all other System patient registration areas; (ii) directly provide to each patient written summary information describing the Policy along with financial assistance contact information in all admission, patient registration, discharge, billing and collection written communications; (iii) post the Policy on the System's web site with clear linkage to the Policy on the System's home page; (iv) educate all admission and registration personnel regarding the Policy so that they can serve as an informational resource to patients regarding the Policy; and (v) include the tag line "Please ask about our Financial Assistance Policy" in all Hartford Healthcare written advertisements.

V. Relation to Free Bed Funds. If a patient applies for Financial Assistance, Hartford Healthcare facilities will determine his or her eligibility for Financial Assistance and or Free Bed Funds.

VI. Regulatory Compliance. The System will comply with all state and federal laws, rules and regulations applicable to the conduct described in this Policy.

Reviewed By:	Niobus Queiro, Revenue Cycle Director, Hartford Healthcare Corporation
	Shelly McCafferty, PFS Director, Hartford Healthcare Corporation
	Becky Peters, PAS Director, Hartford Hospital
	Joan Feldman, Legal Counsel to Hartford Healthcare Corporation
Approved By:	**_____ Thomas Marchozzi, EVP & CFO Hartford Healthcare Corp.**
Date:	**_____October 1, 2010_____**

Issued Date: 08/16/2010

Federal Poverty Guidelines 2011

(Does not include Alaska and Hawaii)

Percent of Poverty	Family Size							
	1	2	3	4	5	6	7	8
100	$10,890.00	$14,710.00	$18,530.00	$22,350.00	$26,170.00	$29,990.00	$33,810.00	$37,630.00
125	$13,612.50	$18,387.50	$23,162.50	$27,937.50	$32,712.50	$37,487.50	$42,262.50	$47,037.50
150	$16,335.00	$22,065.00	$27,795.00	$33,525.00	$39,255.00	$44,985.00	$50,715.00	$56,445.00
175	$19,057.50	$25,742.50	$32,427.50	$39,112.50	$45,797.50	$52,482.50	$59,167.50	$65,852.50
185	$20,146.50	$27,213.50	$34,280.50	$41,347.50	$48,414.50	$55,481.50	$62,548.50	$69,615.50
200	$21,780.00	$29,420.00	$37,060.00	$44,700.00	$52,340.00	$59,980.00	$67,620.00	$75,260.00
225	$24,502.50	$33,097.50	$41,692.50	$50,287.50	$58,882.50	$67,477.50	$76,072.50	$84,667.50
235	$25,591.50	$34,568.50	$43,545.50	$52,522.50	$61,499.50	$70,476.50	$79,453.50	$88,430.50
250	$27,225.00	$36,775.00	$46,325.00	$55,875.00	$65,425.00	$74,975.00	$84,525.00	$94,075.00
275	$29,947.50	$40,452.50	$50,957.50	$61,462.50	$71,967.50	$82,472.50	$92,977.50	$103,482.50
300	$32,670.00	$44,130.00	$55,590.00	$67,050.00	$78,510.00	$89,970.00	$101,430.00	$112,890.00
325	$35,392.50	$47,807.50	$60,222.50	$72,637.50	$85,052.50	$97,467.50	$109,882.50	$122,297.50
350	$38,115.00	$51,485.00	$64,855.00	$78,225.00	$91,595.00	$104,965.00	$118,335.00	$131,705.00
375	$40,837.50	$55,162.50	$69,487.50	$83,812.50	$98,137.50	$112,462.50	$126,787.50	$141,112.50
400	$43,560.00	$58,840.00	$74,120.00	$89,400.00	$104,680.00	$119,960.00	$135,240.00	$150,520.00

Revised 6/2011

Financial Assistance Application Form

*(Form Must Be **COMPLETELY** Filled Out – **PLEASE PRINT**)*

100 Grand Street New Britain CT 06050
(860) 224-5181

Guarantor Name: _____

Patient Name: _____

Medical Rec#: _____ **Account #:** _____

Address: _____

_____

Social Security #: _____ **DOB:** _____ **Telephone #:** _____

Cell Phone #: _____ **# of Dependents In Household:** _____

Patient: WWII Veteran? YES ___ NO ___ **Spouse: WWII Veteran? YES ___ NO ___**

Name of Dependents:	**Date of Birth:**	**Relationship:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospital Account Information

Account Number	List Units #	Date of Service	Balance Due	FC	Diagnosis Description

Employer	Patient	Spouse
Gross Wages		
Child Support/Alimony Received		
Pension		
Unemployment Benefits		
Social Security Benefits		
Rental Income Received		
Other Income *(please specify)*		
TOTAL INCOME		

Expense Information- Hardship Referrals Only

Expenses	Monthly Payments	Outstanding Balance
Mortgage		
Rent		
Auto Loan		
Medical Bills		
Credit Cards: Other: _____		
Utilities; **Gas, Oil, Electric**		
Other (*Please specify*)		
TOTAL EXPENSES		

Before determination will be made, the following information must be provided:

☐ Photo I.D., such as a driver's license, passport, or immigration identification card.
☐ Proof of Income, such as a Current Pay Stub, Bank Statement, Social Security Record, or Letter of Support.
☐ An approval or denial letter from the State of Connecticut Department of Social Services for a completed medical application.

The above statements are true and accurate. I understand that available funds are used only after all other sources of third party payment have been exhausted. I agree, if requested by the hospital, to cooperate and follow through with applications for State, and/or General Assistance as well as any other Third Party Payors. This application is subject to approval of the Financial Assistance Committee.

Applicant Signature_____ **Date:** _____

Application Taken By: _____

Comments: _____

Approval: _____

Denied: _____

Formulario de solicitud de asistencia financiera

*(Debe llenar **COMPLETAMENTE** el formulario - **USE LETRA DE IMPRENTA**)*

The Hospital of Central Connecticut
A Hartford HealthCare Partner
100 Grand Street New Britain CT 06050
(860) 224-5181

Nombre del garante: _____

Nombre del paciente: _____

No. de registro médico: _____ **No. de cuenta:** _____

Domicilio: _____

_____

No. de seguro social: _____ **Fecha de nacimiento:** _____ **No. de teléfono:** _____

No. de teléfono celular: _____ **No. de dependientes en el hogar:** _____

Paciente: ¿Es un veterano de la segunda guerra mundial? SÍ ___ NO ___
Cónyuge: ¿Es un veterano de la segunda guerra mundial? SÍ ___ NO ___

Nombre de los dependientes:	**Fecha de nacimiento:**	**Vínculo:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Información de la cuenta del hospital

Número de cuenta	No. de unidades de lista	Fecha de servicio	Saldo adeudado	FC	Descripción del diagnóstico

Información de los ingresos

Empleador	Paciente	Cónyuge
Sueldo bruto		
Manutención para niños/Pensión alimenticia recibi		
Pensión		
Beneficios de desempleo		
Beneficios del seguro social		
Ingreso de rentas recibido		
Otros ingresos *(especifique)*		
INGRESO TOTAL		

Información de gastos- Únicamente derivaciones por dificultades

Gastos	Pagos mensuales	Saldo pendiente
Hipoteca		
Alquiler		
Préstamo vehicular		
Facturas por atención médica		
Tarjetas de crédito: Otro: _____		
Servicios públicos: **combustible, gas, electricidad**		
Otros *(especifique)*		
GASTOS TOTALES		

Antes de que se tome una decisión, se debe proporcionar la siguiente información:

- ☐ Identificación con fotografía, tal como una licencia de conducir, pasaporte o tarjeta de identificación de inmigrante.
- ☐ Prueba de ingresos, tal como una boleta de pago actual, estado de cuenta bancario, registro del seguro social o carta de apoyo financiero.
- ☐ Una carta de aprobación o rechazo del Departamento de Servicios Sociales del Estado de Connecticut para una solicitud médica presentada.

Las declaraciones anteriores son correctas y verdaderas. Entiendo que los fondos disponibles sólo se utilizan después de que se hayan agotado todas las demás fuentes de pago de terceros.
Acepto, si el hospital lo requiere, cooperar y presentar solicitudes para Asistencia general y/o estatal así como cualquier otro tercero responsable de los pagos. Esta solicitud está sujeta a la aprobación del Comité de Asistencia Financiera.

Firma del solicitante_____**Fecha:** _____

Solicitud tomada por: _____

Comentarios: _____

Aprobación: _____

Rechazada: _____

Formularz z wnioskiem o pomoc finansową

*(Niniejszy formularz należy wypełnić **W CAŁOŚCI –PROSZĘ WYPEŁNIĆ PISMEM DRUKOWANYM**)*

The Hospital of Central Connecticut
A Hartford HealthCare Partner
100 Grand Street New Britain CT 06050
(860) 224-5181

Imię i nazwisko poręczyciela: _____

Imię i nazwisko pacjenta: _____

Nr dokumentacji medycznej: _____ **Nr rachunku:** _____

Adres: _____

_____

Nr Social Security: _____ **Data urodzenia:** _____ **Nr telefonu:** _____

Nr telefonu kom.: _____

Liczba osób pozostających na utrzymaniu w gospodarstwie domowym: _____

Pacjent: Weteran II wojny światowej? TAK ____ NIE ___
Małżonek(ka): Weteran II wojny światowej? TAK ____ NIE ____

Imiona i nazwiska osób pozostających na utrzymaniu:	Data urodzenia:	Powiązanie:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Informacje o koncie szpitalnym

Numer konta	Lista Jednostki	Data usługi	Kwota pozostała do	FC	Opis diagnozy

Informacje o dochodach

Pracodawca	Pacjent	Małżonek(ka)
Zarobki brutto		
Otrzymywane zapomoga na dziecko/alimenty		
Emerytura		
Zasiłek dla bezrobotnych		
Świadczenia z tytułu ubezpieczenia społecznego		
Dochód z wynajmu		
Inne *(proszę określić)*		
CAŁKOWITY DOCHÓD		

Informacje o wydatkach- Tylko skierowania w związku z trudną sytuacją finansową

Wydatki	Opłaty miesięczne	Należne saldo
Kredyt hipoteczny		
Czynsz		
Kredyt na samochód		
Rachunki medyczne		
Karty kredytowe: Inne: _____		
Media: **Gaz, olej, elektryczność**		
Inne *(proszę określić)*		
ŁĄCZNE KOSZTY		

Przed rozpatrzeniem wniosku należy dostarczyć następujące informacje:

- ☐ Dokument tożsamości ze zdjęciem, taki jak prawo jazdy, paszport lub karta identyfikacyjna imigranta.
- ☐ Potwierdzenie dochodu, na przykład aktualny odcinek wypłaty, wyciąg z banku, poświadczenie ubezpieczenia społecznego lub deklaracja wsparcia finansowego.
- ☐ Pismo od Departamentu Usług Społecznych Stanu Connecticut z pozytywnym rozpatrzeniem lub odrzuceniem wniosku o pomoc finansową w pokryciu kosztów medycznych.

Powyższe oświadczenia są zgodne z prawdą i dokładne. Rozumiem, że dostępne fundusze są wykorzystywane dopiero po wyczerpaniu wszystkich pozostałych źródeł płatności od stron trzecich. Zgadzam się, na żądanie szpitala, współpracować i realizować kwestię wniosków o pomoc stanową i/lub ogólną, a także od Płatników stron trzecich. Niniejszy wniosek podlega zatwierdzeniu przez Komisję ds. Pomocy Finansowej.

Podpis wnioskodawcy_____ **Data:** _____

Wniosek przyjęty przez: _____

Uwagi: _____

Zatwierdzenie: _____

Odrzucenie: _____

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 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 (i.e. pay stubs, bank statements or previous years federal tax return)

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

FONDOS PARA CAMA GRATUITA

Si usted se encuentra con problemas personales financieros, y esta enfrentando una suma significante de deudas con el The Hospital of Central Connecticut, "Fondos para Cama Gratuita" puede estar disponible para cubrir el costo parcial o entero para servicios de paciente interno o externo y servicios de emergencia brindados en el hospital. Lo siguiente es requerido:

- Que usted haya aplicado para programas de asistencia con el estado en el que reside y le hayan rechazado la elegibilidad. **Pruebas son Requeridas.**

- Que su ingreso del hogar sea de o menos del 250% de las tables Federales del Ingreso de Pobreza. **Pruebas de su Ingreso son Requeridas.**

Si usted cumple con estos requisitos puede obtener una aplicación para cama gratuita, por favor comuníquese al representante financiero del paciente al (860) 224-5181 e incluya la siguiente documentación requerida cuando retorne su aplicación (padres o guardianes pueden aplicar si el paciente es menor de edad):

- Una identificación con foto, como una licencia valida de conducir del estado de CT, pasaporte o tarjeta de inmigración (tarjeta verde)
- Una carta de rechazo del estado de Connecticut para asistencia medica o programa similar si no reside en Connecticut
- Prueba de los (Ej. : prueba de ingreso, estado de cuenta de banco o impuestos de los anos anteriores)

Usted esta en el derecho de reaplicar para "Fondos para Cama Gratuita" si fue rechazado anteriormente.

Revised 10-01-06

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
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, 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 FA policy 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 4 statement cycle (approx. 120 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 $9.99 • 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. • Review 'holds' on account and work appropriately, i.e. check probate, etc.
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 prelisted in the BD prelist screen; making sure the correct collection agency is selected, and note account in Star. *Exception; accounts over $25,000.00, BEFORE prelisting need approval by our Chief Executive Officer. Send printed screen to him for approval before you prelist for Bad Debt. After approval and prelisting, note account with date he signed.
6	The collection agency is responsible to provide the hospital's financial assistance summary information 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, Bad Address. The collection staff will select 'end step' on follow up maintenance screen, and account will fall on the bad debt selection list at 23rd of 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.
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 120 days and 4 statements received.
12	**Financial Assistance:** 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 FA representative changing the Financial Class to 'SU'. Also, they will indentify uninsured patients by the new financial classes of 'SP'; SB; SF; or SR. These patients have already been indentified and have been given an adjustment to each claim. **BAD DEBT RETURNS:** Our collection agencies will return accounts worked and found to be: deceased, skipped, bankrupt, on State Welfare or other to be adjusted off; all other accounts are worked until they have exhausted all efforts and then returned to THOCC. If applicable, those accounts will be reassigned to a 'secondary' collection agency for follow up collection. An electronic email with returned uncollectable accounts is sent by agency 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.