University of Connecticut Health Center

JOHN DEMPSEY HOSPITAL

PATIENT FINANCIAL SERVICES
ORIGINAL EFFECTIVE DATE: 10/31/1981
FISCAL YEAR: 2012-2013

MAJOR CLASSIFICATION: Patient Financial Services

TITLE: Write off policy

PURPOSE

This section of the Patient Financial Services Policy and Procedure Manual is intended to specifically define the policy for determining when an account is to be written off as a bad debt.

ORGANIZATION OF SECTIONS

A. Statement of Policy
B. Accounts Exempt from Write-Off Policy
C. Balances Not Submitted for Write-Off
D. Determination of Uncollectibility
E. Medical Authorization [*Audits*]
F. Preparation of Write-Off Batches/Approval Process [*Documentation/Forms required*]
G. Input of Write-Off Batches [*Approval Process*]
H. Reconciliation of Write-Off Batches [Final Disposition of Debt]
I. Non-Medicare Bad Debt Recovery [*Applying payments on Accounts Written Off*]
J. Medicare Bad Debt Recovery [*Applying payments on Accounts Written Off*]

A. STATEMENT OF POLICY

The process of recommending accounts for write-off is to take place only after all available resources for the collection of a debt for services have been exhausted. This collection process includes billing third party payers (insurance carriers, etc.) direct billing and dunning to the patient or guarantor, in-house collection activity (i.e.: phone calls, dunnings, small claims filing, etc.) as well as referral to outside collection agencies or to the Attorney General's Office if appropriate. Requests for write-offs in the category of medical authorizations [*and/or audits*] as designated in Section E of this policy are excluded from the aforementioned collection process.

B. EXCEPTIONS TO THE WRITE-OFF POLICY

1. **Balances less than or equal to $50.00**. [*Balances under $10.*]

2. Patient Deceased-No Estate: The self-pay balance(s) of a patient who has expired where there is verification that no estate exists.

3. Bankruptcy: Where a patient/guarantor has filed and been declared bankrupt by the court.

4. Administrative Recommendation: Those accounts that have been recommended for write-off by the Hospital or Health Center Administration because of the medically sensitive situation or other unusual circumstance.

5. Verification of Charges: Where charges on a patient's bill cannot be substantiated in the medical records during the course of a third party charge audit.

6. Accounts with a credit balance after all efforts have been exhausted to resolve the balance.

C. BALANCES THAT ARE NOT TO BE SUBMITTED FOR WRITE-OFF ARE:

1. When the balance remaining after a third-party payment is a discount or a per diem adjustment. [*These amounts are not considered for write-off.*]

2. Medicare Part A deductibles and co-insurances that have been returned as uncollectible by the agency. These amounts are handled as a Medicare bad debt adjustment.

3. **Any tax amounts exempt under ERISA or any federal law.**

D. DETERMINATION OF UNCOLLECTIBILITY

An account becomes uncollectible when the patient or responsible party does not pay for the billed charges after a number of steps have been taken by Patient Financial Services to encourage payment. [*If a patient is represented by an Attorney the staff is required to have the Attorney submit a Hipaa compliant form signed by the patient to discuss the account, and send bills to the Attorney's Office if requested.(If the conversation is related to workers compensation, a Hipaa notice is not required.) In the event the Attorney offers a letter of protection, the Hospital does not honor this arrangement as it is not a guarantee of reimbursement for the expenses incurred by the patient. The patient must pay the cost of services up front, and when case settles the patient can discuss settlement issues with their Attorney. If the patient refuses to pay the costs up front the Hospital staff can refer the account to outside Collection Agency or Attorney General Office for further collection activity*.]

[*For those in which the patient is responsible for the entire amount or a portion of the amount, the Collection Unit of Patient Services duns the responsible party. The dunning process is based on dollar due regardless of inpatient or outpatient service status.*]

The responsible party on any account, in which the patient portion falls in the range listed below has not been paid in full, receives during a ninety (90) day period [*at least the following:*]:

[*1. Two computer generated monthly billing statements*].

[*2. Two individual dunning letters sent approximately 15 days after the statement.*]

Balances Under $500

1. Two computer-generated monthly billing statements.

Balances Above $500

1. **Two computer-generated monthly billing statements.**
2. **Two telephone calls from collection personnel**
3. **A final dunning notice from the collector. This letter will notify the patient of the action that will be taken by the Patient Financial Services Department if the account remains unpaid, which could include Small Claims Referral or referral to the Attorney General's Office.**

If there is no response, one or more of the following activities occur:

Balances Less Than or Equal To $500 [*Balances Under $100*]

1. Referral to Collection Agency

Balances Greater $500 and Less Than $2,000 [*Balances $100-$750 and any balance with no assets]*

1. **Verification of Assets** [*Phone Calls*]
2. Referral to Collection Agency
3. **Referral to Small Claims Court**

[*Balances $750- $1,500 with Assets*

1. *Phone Calls*
2. *Notice of Intent to Sue*
3. *Small Claims Court*]

Balances Greater than $2,000 [*Balances of $1,500 and over with Assets*]

1. **Verification of Assets** [*Phone Calls*]
2. Credit Report
3. Property Assessment with Town Hall of patient's residence
4. **Referral to Collection Agency**
5. Referral to Attorney General to pursue legal action

[*Employment*]

Outside Collection Agencies:

Accounts are referred to Collection Agencies on a monthly basis. The Agencies send an initial dunning letter to verify address and to stimulate payment. In addition, they perform asset and employment verification. [*In addition, they do asset and employment verification.*] If the patient or responsible party does not respond in ninety (90) days, [*and the balance is under $100*], the account is referred to the

attorney that represents the Collection Agency. The attorney pursues the account via wage attachment, small claims, liens, etc. The attorney will then return those accounts in which payments are not forthcoming. **It is expected that any account that has been turned over for collection, and has not experienced any activity within 180 days will be returned to the Hospital as a Bad Debt Write-off.**

Assistant Attorney General:

The Assistant Attorney General handles self-pay and various types of third party accounts referred from our [*the*] collection staff, [*as well as third party accounts referred from our*] billing staff, **and the Department's Director and Assistant Director.** [*These*] **Examples of** third party accounts include: **General Assistance** [*Town/City welfare*], Motor Vehicle Accidents, Workers Compensation, and Commercial Insurance [*carriers, etc.*]. **Accounts will be returned to Patient Financial Services as an uncollectible write-off after all legal avenues have failed to produce payment within a reasonable amount of time. The exception to this is if a property lien has been filed; these accounts may remain active until property is sold or exchanges ownership. If a compromise settlement has been reached as the result of a legal suit, the remaining balance will be referred for write-off. Compromise settlements will only be accepted if the Assistant Attorney General verifies that it is the best option available and/or percentage comparable to John Dempsey Hospital's.** [*After all legal avenues have been used, the uncollectible account, whether self-pay or third party, will be returned for write-off. If a compromise settlement has been reached as a result of legal suit, the remaining balance will be referred for write-off.*]

E. MEDICAL AUTHORIZATION

1. Authorization

Various third parties will require that authorization be obtained either prior to or during treatment. Many of these requirements, especially with HMO's and other managed care plans, are included in their contractual agreements with the hospital. If authorization is not obtained, the claim will be denied and neither the patient nor the third party will be liable. Some authorization requirements are specific to types of service while others are across the board. [*Examples of treatments that need authorization are: psychiatric care, physical therapy and out of state welfare care.*] If authorization is not obtained and the hospital is at fault, the account will be processed for write-off.

2. Medical Records

There are situations where the third party needs medical information in order to process the claim. [*Examples of these would be: CT Scan Reports, EEG Reports, drug prescriptions.*] If this information **is not provided to Patient Financial Services** [*cannot be obtained from*] **by the** Medical Records or **the ancillary** department **within 60 days of the date the information was requested,** the account will be processed for write-off.

[*3. Verification of Charges*

If the charge information cannot be substantiated in the Medical Records or the Ancillary Department, the charge amount will be processed for write-off.]

F. THE PREPARATION OF WRITE-OFF BATCHES

Write-off batches are prepared in advance of the Finance Corporation meeting and forwarded to Financial Administration. [*Bad Debt write-offs are entered into the Hospital billing system upon receipt of notice from Collection Agencies, Bankruptcy accounts and the like.*]
Each batch must have a write-off transmittal number assigned to it, and must list the number of accounts and their associated dollar amount. The batches must have cover letters addressed to the Executive Director of the University Of Connecticut Health Center (UCHC) Finance Corporation on UCHC letterhead (Attachment 1), and to the Chairman of the Board of the UCHC Finance Corporation on UCHC Finance Corporation letterhead (Attachment 2). The write-off transmittal number, the number of uncollectible accounts and the dollar amount must be identical on each of these cover letters.

Each transmittal must be accompanied by a list showing: Patient Name, Medical Record Number and/or Admission Numbers, the balance and a sub-code which indicates the reason write-off (Attachment 3). The total number and dollar amount of this list must match those on the transmittal letters.

This list must be summarized in two different ways: the number and dollar amount of accounts by write-off subcode and the number and dollar amount of accounts in the following balance range:

Less than or equal to $500
$501 -$2,500
$2,501 -$10,000
Greater than $10,000

An example of these summaries is provided in (Attachment 4). The totals of the summaries must be identical to those on both cover letters.

Once each write-off batch is balanced and ready for forwarding to Financial Administration, they must be signed by the Director of Patient Financial Services or the Assistant Director of Patient Financial Services in his/her absence, and must be logged into the write-off transmittal log. [*This report is logged by the Collection Supervisor in a excel spread report*] **A copy of each batch must be made and kept in the pending basket. The original batch can then be sent to Financial Administration.**

For computing and audit purposes, one account will be counted for each Medical Record Number. Two tapes showing the sum of the account balances must accompany each write-off batch.

[F. DOCUMENTATION/FORMS REQUIRED

1) *All Collection Agency returns must be electronic*
2) *The Collection Agency returns will be matched against warehouse to validate IDX balance.*
3) *If the Collection Agency return balance does not match the warehouse, the visit will be reviewed to determine the correct amount before the entry is made. The adjustment for Bad Debt must equal Collection Agency Report.*

The request package for write-offs of accounts returned by the collection agency and its attorney will contain a list of accounts, a list of codes indicating the reason for the write-off and a cover Letter from Patient Services.

The request package for write-offs of accounts by the Assistant Attorney General will contain a cover letter detailing the activity on the account and why it should be written off as well as a cover letter from Patient Services.

The request package for write-offs due to lack of medical information and/or documentation will contain a list of accounts, a list of codes indicating reason for write-off, and a cover letter from Patient Services.]

G. INPUT OF WRITE-OFF BATCHES

A copy of the minutes of the Finance Corporation meeting is sent to the Patient Financial Services Department. These minutes include a list of the write-off transmittals that were approved for bad debt write-off. The dates these transmittals were approved must be entered into the write-off transmittal log [*Inputted by the Collection Supervisor*]. It is important to note that some of these transactions may result in a credit balance, or may not register at all because the account was partially paid or paid in full in the interim between the time the account received departmental approval for write-off and the time the Finance Corporation approved the write-off. If the batch file indicated that the transaction will result in a negative balance, the full amount will, none the less, be input and will be reconciled at a later date (see section

If the account does not register at all, the account must be highlighted on the write-off Transmittal and used for reference during reconciliation.

One batch will be created for each write-off transmittal. A cover sheet will be attached to the batch once it has been completed, listing the number of the batch, the transaction code used and the dollar amount of the batch (Attachment 5).

Each transmittal approved by the Finance Corporation will be input into the system before the end of the month.

[*G. APPROVAL PROCESS*

The Patient Services Department will gather the appropriate documentation and prepare a transmittal letter which will be forwarded to the following for approval:

1. *Hospital Controller*
2. *Associate Hospital Director*

The transmittal and accompanying documentation will then be sent to the John Dempsey Hospital Finance Corporation for approval to write-off the account as uncollectible. A log is kept on all transmittals.]

H. RECONCILIATION OF WRITE-OFF BATCHES

It is important to document which accounts approved for write-off did not get written off for the approved amount and the reason this occurred.

The reconciliation batch is prepared by first reviewing the batch edit of the original write-off batch (Attachment 6). If the amount listed in the "amount" section is greater than the amount listed in the "balance" section, then a reconciliation batch is necessary. Each account where this occurs needs to be reconciled.

An account reconciled by inputting transaction code "80" for the differences between what was requested for write-off and what was actually written off. There should be one reconciliation batch for each write-off transmittal that requires reconciliation.

The reconciliation batch should be closed once all the adjustments have been entered, and the number of the batch should be written on the original write-off batch edit.

Once the edit for the reconciliation batch(es) is received, the following items must be documented on the edit(s): the write-off transmittal being reconciled, the amount approved for write-off by the Finance Corporation, the actual amount written off, and the difference (Attachment 7). The sum of the accounts on the batch edit must equal the difference between what the Finance Corporation approved for write-off and what was actually written off. Note that if a 73 transaction code is among the entries on the reconciliation batch (which would occur if an amount greater than what was originally approved is needed to make the account balance $0), this amount must be subtracted twice from the control amount in order to reflect the total or "Absolute value" of the amounts input.

Once the reconciliation batches have been completed, a memorandum must be sent to the Associate Hospital Director (Finance) describing the discrepancies (Attachment 8), with a copy of the reconciliation batch(es) attached.

All of the write-off transmittals, write-off batch edits, reconciliation batch edits, and Finance Corporation minutes must be collated. A large elastic band is placed around them, and referred to the Assistant Director of Patient Financial Services, who will file them.

The Patient Financial Services Department will hold two fiscal years' worth of reconciled write-off transmittals: the present fiscal year and the previous fiscal year. Any remaining transmittals will be sent to the archive for storage.

[*H. FINAL DISPOSITION OF DEBT*

When the approval to dissolve the debt has been granted, a member of Patient Services will input the appropriate transaction bring the account to zero status.

The write-off package is then retained for seven years before destruction. The transmittal log is updated.]

I. NON-MEDICARE BAD DEBT RECOVERY

Payments received on accounts written-off as Bad Debt are broken down into 2 recoveries *A) Small Balances B) Large Balances*. The funds received are recovery of Bad Debt remitted either by the Collection Agencies or by Debtors. These recoveries are on accounts previously recorded as uncollectible, and written-off as a Bad Debt. The funds received are to "Net-off" all or part of the Bad Debt write-offs equal to the $$ received. The following examples show how the process is done:

(Examples):

A) Small Balance Recovery [*Balances under $25.00*]

Name: DOE, JOHN I MRN: XXXXXXXXX VTYP: OPOP Adm#: XXXXXXX I6VC.A
Adm Dt: 12/22/2005 Dis Dt: 12/22/2005 FB Dt: 01/03/2006 Stmt Dt: 03/08/2007
Tot Chgs: 185.01 Billed: 185.01 Unbilled: 0.00 Late: 0.00
Pymts: -69.84 Adjs: -115.17 Bal: 0.00 ARFSC: 850

V I S I T A/R T R A N S A C T I O N S

Entry Dt	Trans Dt	Plan	ARCTR	Code	Description	Type	Amount	Ind
06/28/06	06/28/06	0950	7H	942	TRANSFER TO AMERI	TADJ	5.10	M
02/17/07	02/17/07	0950	7H	902	SMALL BALANCE WRI	DADJ	-5.10	
12/06/07	12/06/07	0950	7H	556	PFS SMALL BAL W/O	DADJ	5.10	
12/10/07	12/07/07	0950	7H	415	SELF PAY - COLL R	PAYM	-5.10	

B) Large Balance Recovery [*Balances over $25.00 & above*]

Name: DOE, JOHN MRN: TXXXXXXXX VTYP: OPUL Adm#: XXXXXXX I6VC.A
Adm Dt: 07/15/2003 Dis Dt: 07/15/2003 FB Dt: 08/07/2003 Stmt Dt: 01/31/2004
Tot Chgs: 2218.00 Billed: 2218.00 Unbilled: 0.00 Late: 0.00
Pymts: -204.06 Adjs: -2013.94 Bal: 0.00 ARFSC: 1

V I S I T A/R T R A N S A C T I O N S

Entry Dt	Trans Dt	Plan	ARCTR	Code	Description	Type	Amount	Ind
	Beginning							
02/13/04	02/13/04	0482	4H	934	TRANSFER TO NAIR	TADJ	204.06	M
05/17/04	05/13/04	0482	4H	415	SELF PAY - COLL R	PAYM	-30.00	
07/13/04	07/08/04	0482	4H	415	SELF PAY - COLL R	PAYM	-30.00	
10/12/04	10/08/04	0482	4H	415	SELF PAY - COLL R	PAYM	-30.00	
11/04/04	11/04/04	0482	4H	415	SELF PAY - COLL R	PAYM	-30.00	
02/07/05	02/07/05	0482	4H	415	SELF PAY - COLL R	PAYM	-30.00	
10/27/06	10/27/06	0482	4H	590	BAD DEBT WRITE OF	CADJ	-54.06	
12/06/07	12/06/07	0482	4H	591	BAD DEBT RECOVERI	CADJ	54.06	
12/10/07	12/07/07	0482	4H	415	SELF PAY - COLL R	PAYM	-54.06	

**Clm # 4 0.00 Bills -204.06 Pymts 204.06 Adjs 0.00 Bal
**Plan 0482 0.00 Bills -204.06 Pymts 204.06 Adjs 0.00 Bal

J. MEDICARE BAD DEBT RECOVERY

Payments received on accounts written-off as Medicare Bad Debt are broken down into 2 recoveries *A) Small Balances B) Large Balances*. The funds received are recovery of Medicare Bad Debt remitted either by the Collection Agencies or by Debtors. These recoveries are on accounts previously recorded as uncollectible, and written-off as a Medicare Bad Debt. The funds received are to "Net-off" all or part of the Medicare Bad Debt write-offs equal to the $$ received. The following examples show how the process is done:

(Examples): A) Small Balance Recovery [*Balances under $25.00*]

Name: DOE, JOHN MRN: TXXXXXXXX VTYP: ORAD Adm#: XXXXXXX I6VC.A
Adm Dt: 12/10/2004 Dis Dt: 12/10/2004 FB Dt: 12/21/2004 Stmt Dt: 10/07/2005
Tot Chgs: 332.00 Billed: 332.00 Unbilled: 0.00 Late: 0.00
Pymts: -89.98 Adjs: -242.02 Bal: 0.00 ARFSC: 850
V I S I T A/R T R A N S A C T I O N S

Entry Dt	Trans Dt	Plan	ARCTR	Code	Description	Type	Amount	Ind
04/29/05	04/29/05	0483	4H	935	TRANSFER TO NAIR	TADJ	18.00	M
10/01/05	10/01/05	0483	4H	902	SMALL BALANCE WRI	DADJ	-18.00	
12/06/07	12/06/07	0483	4H	556	PFS SMALL BAL W/O	DADJ	18.00	
12/07/07	12/07/07	0483	4H	415	SELF PAY - COLL R	PAYM	-18.00	

**Clm # 4 0.00 Bills -18.00 Pymts 18.00 Adjs 0.00 Bal
***Plan 0483 0.00 Bills -18.00 Pymts 18.00 Adjs 0.00 Bal

B) Large Balance Recovery [*Balances over $25.00 & above*]

Name: DOE, JOHN MRN: TXXXXXXXX VTYP: OPGR Adm#: XXXXXXX I6VC.A
Adm Dt: 05/01/2001 Dis Dt: 05/31/2001 FB Dt: 06/05/2001 Stmt Dt: 09/30/2005
Tot Chgs: 126.75 Billed: 126.75 Unbilled: 0.00 Late: 0.00
Pymts: -262.14 Adjs: 135.39 Bal: 0.00 ARFSC: 850
V I S I T A/R T R A N S A C T I O N S

Entry Dt	Trans Dt	Plan	ARCTR	Code	Description	Type	Amount	Ind
12/19/03	12/19/03	0481	5H	933	TRANSFER TO CENTU	TADJ	67.17	M
09/06/05	09/06/05	0481	5H	594	MEDICARE BAD DEBT	CADJ	-67.17	
08/09/07	08/08/07	0481	5H	415	SELF PAY - COLL R	PAYM	-5.09	
08/09/07	08/09/07	0481	5H	592	MEDICARE BAD DEBT	RECOV CADJ	5.09	
09/07/07	09/07/07	0481	5H	415	SELF PAY - COLL R	PAYM	-25.00	
10/02/07	10/02/07	0481	5H	592	MEDICARE BAD DEBT	RECOV CADJ	50.24	
10/04/07	10/03/07	0481	5H	415	SELF PAY - COLL R	PAYM	-25.24	
12/06/07	12/06/07	0481	5H	592	MEDICARE BAD DEBT	RECOV CADJ	11.84	
12/10/07	12/07/07	0481	5H	415	SELF PAY - COLL R	PAYM	-11.84	

**Clm # 5 0.00 Bills -67.17 Pymts 67.17 Adjs 0.00 Bal
***Plan 0481 0.00 Bills -67.17 Pymts 67.17 Adjs 0.00 Bal

University of Connecticut Health Center
John Dempsey Hospital

Patient Financial Services
Department

Date: Dec 5, 2005

Board of Directors
University of Connecticut Health Center
Finance Corporation 263
Farmington Avenue Farmington, CT 06032

Dear Board of Directors:

In accordance with the policies and procedures governing the write off of the uncollectible account receivable of the John Dempsey Hospital, I recommend that the Board approve transmittal numbers Wxxxx-Wxxxx requesting the write off of 178 uncollectible accounts totaling $392,837.55.

I have reviewed the transmittal letter for proper approvals and the accompanying documentation to determine that the John Dempsey Hospital has followed its write off policy dated September 1, 2009 in representing that the accounts are uncollectible.

Sincerely,

Richard D. Gray, Executive Director:

_____ Date: _____

Susan Herbst, President:

_____ Date: _____

An Equal Opportunity Employer

Street Address: **263 Farmington Avenue**
Munson Level 1
Mailing Address: P.O. Box 4034
Farmington, Connecticut 06034-4034
Telephone: **(860) 679-2795**
Facsimile: **(860) 679-2267**

University of Connecticut Health Center
John Dempsey Hospital

Patient Financial Services Department

Date: Dec 3, 2005

Richard D. Gray
Executive Director
UCHC Finance Corporation
University of Connecticut Health Center
Farmington, Connecticut 06032

SUBJECT: Request to Write Off Uncollectible Hospital Receivable

Dear Mr. Gray:

Enclosed please find a list of transmittal #'s Wxxx-Wxxx writing off of 178 uncollectible accounts totaling $392,837.55. The determination to submit these accounts for write off was made in conformance with the Hospital's write off policy dated September 01, 2009.

All efforts have been exhausted and these accounts have returned to John Dempsey Hospital as uncollectible by our outside collection agency.

Sincerely,

Richard A. Peer
Director, Patient Financial Services
John Dempsey Hospital _____ Date: _____

John Biancamano
Chief Financial Officer _____ Date: _____

An Equal Opportunity Employer

Street Address: **263 Farmington Avenue**
Munson Level 1
Mailing Address: P.O. Box 4034
Farmington, Connecticut 06034-4034
Telephone: **(860) 679-2795**
Facsimile: **(860) 679-2267**

W1202

AAB NON-MEDICARE

REASON CODE	*DESCRIPTION*	*# OF ACCTS*
WE	*JUDGEMENT AND EXECUTION PROOF*	**158**
XS	*JUDGEMENT AND EXECUTION PROOF*	**18**
TOTALS		**176**

SUMMARY OF BALANCE

WE	**UNDER $500**	**158**
XS	**$500 - $2,500.00**	**17**
XS	**$2,501 - $10,000**	**1**
XS	**OVER $10,000**	**0**
	TOTALS	**176**

John Dempsey Hospital

263 Farmington Ave.

P.o. Box 4033

Farmington, CT. 06034-4033

Richard Peer, Director Patient Financial Services

Benjamin Maysonet, Collection Supervisor Patient Financial Services

Re: Report totaling all Bad Debt Written off to Committee

Date Processed	*Trans Number*	*Agency Source*	*<> 500*	*Number of Accounts*	*Amount*
12/2/2004	**Wxxxx**	AAB MEDICARE	**<>**	14	$6,5
12/2/2004	**Wxxxx**	AAB NON-MDCRE	**<>**	94	$76,
12/2/2004	**Wxxxx**	SELF PAY NON MDCRE	**<**	1	$1(
12/2/2004	**Wxxxx**	SELF PAY NON MDCRE	**<**	4	$3
12/2/2004	**Wxxxx**	SELF PAY NON MDCRE	**<**	1	$3
12/2/2004	**Wxxxx**	SELF PAY NON MDCRE	**<**	1	$7

12/2/2004	**Wxxxx**	SELF PAY NON MDCRE	**<**	1	$1(
12/2/2004	**Wxxxx**	SELF PAY NON MDCRE	**<>**	3	$6,8
12/2/2004	**Wxxxx**	ATTORNEY GENERAL	**>**	1	$4,3
12/2/2004	**Wxxxx**	ATTORNEY GENERAL	**<**	14	$2,2
12/2/2004	**Wxxxx**	AAB NON-MDCRE	**<>**	152	$51,
12/2/2004	**Wxxxx**	AAB NON-MDCRE	**<>**	316	$144
12/2/2004	**Wxxxx**	NAIR & LEVIN MEDICARE	**<**	10	$1,2
12/2/2004	**Wxxxx**	AAB NON-MDCRE	**<>**	192	$63,
12/2/2004	**Wxxxx**	AAB NON-MDCRE	**<>**	192	$51,
12/2/2004	**Wxxxx**	NAIR & LEVIN NON-MDCRE	**<**	36	$2,6
12/2/2004	**Wxxxx**	AAB MEDICARE	**<>**	41	$7,6
12/2/2004	**Wxxxx**	NAIR & LEVIN NON-MDCRE	**<**	1	$1
12/2/2004	**Wxxxx**	NAIR & LEVIN NON-MDCRE	**<>**	172	$31,
12/2/2004	**Wxxxx**	NAIR & LEVIN MEDICARE	**<>**	17	$3,6
12/2/2004	**Wxxxx**	AAB NON-MDCRE	**<>**	196	$48,
12/2/2004	**Wxxxx**	NAIR & LEVIN NON-MDCRE	**<>**	171	$27,
12/2/2004	**Wxxxx**	NAIR & LEVIN NON-MDCRE	**<>**	159	$25,
12/2/2004	**Wxxxx**	AAB NON-MDCRE	**<>**	220	$49,
		TOTAL	**<>**	**2009**	**$604**

THE UNIVERSITY OF CONNECTICUT HEALTH CENTER
JOHN DEMPSEY HOSPITAL, UMG/UCHP
ADMINISTRATIVE MANUAL
FY 2012-2013

SECTION:	FINANCIAL MANAGEMENT	NUMBER: 04-005
SUBJECT:	CHARITY CARE	PAGE: 1 0F 3

PURPOSE:

To provide a policy and procedure for the determination and handling of University of Connecticut Heath Center's (UCHC) Charity Care. Charity Care is a financial assistance program offered by the UConn Health Center which provides a reduced cost rate for medically necessary services incurred by State of Connecticut legal residents whose household income does not exceed 250% of the Federal Income Poverty Guidelines for a family unit. Patients must meet the State of Connecticut definition of "Uninsured", having applied and been denied eligibility for any medical or health care coverage provided under the CT Medicaid program, or not be eligible for coverage under the Medicare or CHAMPUS programs, or any other governmental or privately sponsored health or accident insurance. Patients must furnish proof of current income to qualify for charity care.

PROCEDURE:

A. Notice of Charity Care:

Signs in both English and Spanish are posted in the operational areas indicated below:

Health Center Cashier Offices
Financial Counseling Offices
Hospital outpatient departments
Patient Financial Services departments
Hospital Emergency department
Same Day Surgery department
UMG/UCHP Physician Offices

B. Applications for Charity Care:

Patients may obtain an application for Charity Care from Financial Counselors or the Collection units of the Patient Financial Services Department. The completed application must be returned to the attention of the Collections Supervisor of the Patient Financial Services Department.

Financial Counselors, Case Managers, and Social Workers are available to assist the patient with this process. Additionally, UConn Health Center has translation services available through the Language Line services via AT&T to also assist with this process.

C. Eligibility Requirements

All patients who apply for Charity Care consideration must be State of Connecticut legal residents whose household income does not exceed 250% of the Federal Income Poverty Guidelines for a family unit. Patients must meet the definition of "Uninsured", having applied and been denied eligibility for any medical or health care coverage provided under the CT Medicaid program, or not be eligible for coverage under the Medicare or CHAMPUS programs, or any other governmental or privately sponsored health or accident insurance. Patients must furnish proof of current income to qualify for charity care.

Federal Income Poverty Guidelines will be adjusted annually based upon the inflation rate as determined by the Consumer Price Index (CPI) as published at the end of the calendar year.

D. Services Covered by the Program:

Medically necessary services, which are deemed essential to identify or treat a patient's condition, illness or injury, based on the patient's symptoms, diagnosis or treatment of the underlying condition, in accordance with professional standards of medical care generally accepted in the medical community.

E. Services NOT Covered:

Not medically necessary services, which are solely for the convenience of the patient

Disputes with respect to medically necessary services may be appealed to the Associate Dean for Clinical Affairs

F. Application Documentation Requirements:

1. Applications must include documentation of all current household income. The required form of documentation will be one or more of the following:

   a. Your four (4) most recent consecutive weekly paystubs, two consecutive bi-weekly or semimonthly paystubs. Paystubs must include employee's name.
   b. A statement from your employer on company letterhead stating your gross wages for the last four (4) weeks, signed by your employer.
   c. If self-employed, a notarized Self-employment Worksheet for the last six (6) calendar months and current 1040 IRS form including all relevant schedules (C, D, E, SE, K, etc.)
   d. Report of Confidential Social Security Benefits, Form 2458, available at the local Social Security office, OR a copy of your Social Security or Supplemental Security Income (SSI) check, OR a statement from the bank if you have direct deposit, OR your most recent Social Security Award Notice, Form SSA-4926SM.
   e. Pension of annuity check stubs, OR a letter from the payer on the letterhead of the payer stating the gross amount.
   f. Printout of Unemployment Compensation Benefits from the Department of Labor (DOL) or from the DOL website at: www.ctdol.state.ct.us
   g. Workman's Compensation of Disability Insurance (short term or long term) statement showing benefits and period covered.
   h. Signed statements indicating the amount and frequency of payments or relatives who are contributing to your household's support.

2. Patient's whose income is known to exceed the poverty income guidelines must also provide documentation of their assets, which incorporate the following items:

   a. Savings and passbook accounts
   b. Stocks, bonds, and certificates of deposit
   c. Money market accounts
   d. Annuities
   e. Pensions

3. Applications must include documentation of unpaid UCHC expenses. Any unpaid UCHC expenses must be documented by a billing invoice and a balance due statement.

4. Proof of State of Connecticut legal residency.

G. Eligibility Determination

1. An applicant will be considered eligible for Charity Care consideration only if eligibility and documentation requirements are met, and the application is returned within 90 days of receipt.

2. After making the eligibility determination, the Collection Supervisor or their designee will notify the patient of the decision in writing within three business days.
   a. Approvals $.01 to $2,499 Patient Access Financial Counselors
   b. Approvals $2,500 to $4,999 Patient Accounts Collection Supervisor
   c. Approvals $5,000+ Director, Patient Financial Services

3. Approved Charity Care applications will cover only those services where payment is due from the patient at the time of the eligibility determination. Patients may reapply for Charity Care on a per episode basis. Also, if additional services are requested related to the current treatment, those services will be covered as well under the initial application.

4. Patient Accounts Collection Supervisor will monthly audit 5 random applications granted for less than $2,500 to ensure compliance with program.

H. Collection Procedure

1. Normal billing procedures will continue during the application process. However, the account will not be referred to an outside collection agency, or if the account is already with an outside collection agency, collection efforts will be delayed until final determination is made on the patient's eligibility for Charity Care.

2. Control logs are maintained by the collection department for John Dempsey Hospital (JDH) and University Medical Group (UMG) to record allowances processed by fiscal year and will include the transaction date, the patient name and patient visit number(s), the transaction amount and the year to date total. The JDH control log is made available to the State of Connecticut's Office of Health Care Access upon request. Applications will be retained for a six (6) month period after the end of the fiscal year and logs are retained for permanently for audit and statistical purposes.

Mike Summerer MD. MS. Interim Hospital Director
Date Issued: 2/95
Date Reviewed: 10/95; 10/97
Date Revised: 12/97, 02/12

John Dempsey Hospital Patient Financial Services Self Pay Collection Policy

Fiscal Year 2012 – 2013

I. ACCOUNTS RECEIVABLE

The policy of the collection unit is that all accounts are due and payable within 120 days of the date they become self-pay. Before we actively work the self pay receivables in this manner, we must be comfortable with the attitude that once the account is self pay that it is self pay "for life", and any and all reasonable attempts have been made to collect the account from other payment sources.

1. Small accounts (under $500)

   The patient/guarantor would receive a first dunning statement giving them 30 days for full payment or contact from them. If no activity after 30 days, the patient/guarantor receives a second and final dunning statement demanding payment within 30 days. If no response at all after 60 days, the account should be forwarded to a collection agency.

2. Mid range accounts ($501 - $999.99)

   The patient/guarantor would receive a first dunning statement giving them 30 days for full payment or contact from them. If no activity after 30 days, the patient /guarantor receives a second and final dunning statement demanding payment within 30 days.
   We make an attempt to contact the patient/guarantor 2 or more times to determine their ability to pay after the first dunning statement is sent.
   If no response at all after 60 days, the account should be forwarded to a collection agency.

3. Large accounts (over $1,000)

   The patient/guarantor would receive a first dunning statement giving them 30 days for full payment or contact from them.

   We make an attempt to contact the patient/guarantor 2 or more times to determine their ability to pay after the first dunning statement is sent.

   After 60 days, we call the patient/guarantor one final time and follow up with one final dunning statement if the patient still has not responded. If the patient does not respond to this inquiry, the account can be referred over to a collection agency or the Connecticut Attorney General's Office (account balances over $2,000 with assets).

If you identify insurance coverage for a visit, or if a patient provides insurance information for a visit, or if a visit has been incorrectly denied by the insurance company, you can have the patients visit billed to the insurance carrier by the Insurance Billers. Before any insurance rebilling can occur, you must verify that there is insurance coverage effective for the date of service and services rendered. After verification, the account balance should be transferred to the insurance Financial Class.

II. CREDIT CARDS

The Policy of the credit cards is in conformance with State Auditors, Ethics & Compliance Department of the University of Connecticut Health Center John Dempsey Hospital. This Policy took place on 03/14/2011.

John Dempsey Hospital

Credit Card Procedures

The procedures outlined are to assist the John Dempsey Hospital Patient Financial Services (Accounts Receivable Collectors) process Credit Cards in accordance with Compliance Policies at the University Of Connecticut Health Center/John Dempsey Hospital. The following process is a daily outline of the duties that the Accounts Receivable Collectors need to do on a daily basis.

- Each Collector needs to log into the Global Transport Payment Solutions via the Virtual Terminal Login at the address https://vt.globalpay.com/admin/login.aspx. Then input their Username and Password to enter into the Virtual Terminal Login.

Virtual Terminal Login

Username: JDOE

Username is required

Password: **********

Password is required

Login

Click here if you need help.
Click here for current release notes.

1/11/11: Security Alert: for your protection against fraud, Global Payments recommends changing your password every 30 days and avoiding the sharing of your user credentials. As an additional fraud protection measure, all refunds will require the PNRef number of the original transaction to be processed.

Version: 4.0.0 / AV1

- Once logged into the Virtual Terminal the Collector will <click> "*Credit*" under the Virtual Terminal folder on the left hand side of the screen.
- The next screen will show the Collector how to input the Credit Card information. Here, the Collector will input all the information received from the patient via Mail or by Telephone interview. Once all the fields are inputted, the Collector will <CLICK>" process" and receive a response usually in 2 seconds of <CLICKING> the process button at the bottom of the page.

Credit Card Sale

Card Number:	11111111111111 *
Expiration Date (MMYY):	1111
Subtotal:	1000
Tax Amount:	
Total Amount:	1000

Customer ID:	T01411111 Invalid characters.
Card Holder:	Jane Doe Invalid characters.
Street:	
City:	
Postal/Zip Code:	06040
CV2:	111 ***CV2 NUMBER NEEDS TO BE INPUTTED***
CV Presence:	Not Submitted
Invoice #:	John Doe
PO #:	7555555 ***THE MAXIMUM # OF VISITS IS 2 WITH "/" SYMBOL IN BETWEEN***

☐ Force Duplicate

☑ Card Present ***THE STAFF NEEDS TO UNCHECK THIS BEFORE PROCEEDING***

Receipt Language: English (United States)

Process

Cancel

- The Collector will then print both copies of the receipt, 1 for the patient (if the patient requests), and 1 for the batch to be given at the end of the day to the Cash Posting Department. Each batch will be placed in the orange folder along with the Excel report that each Collector will submit along with the receipts for that days' business.
- If the patient during the course of interview requests a copy of a receipt for the Credit Card Transaction, the Collector will send the patient copy to them.
- The Collector will input into their Excel Credit Card Log to advise the Cashiers how to apply the Credit Card for each Transaction. This report is to be submitted each day that the Collector has processed Credit Card transaction via the Global Virtual Terminal.
- The Collector must "process the Credit Card" as soon as the information is given by the patient via mail distribution or by telephone interview.

CREDIT CARDS

University of Connecticut Health Center

PAGE 1 OF 1

Users: BMAYSO HPOCHO PBARTO JRONDE WVAZQU GHARTS BJOINE

DATE: 02/24/11

Self Pay/Collections

FUND: 6005

263 Farmington Ave, Munson Road 1st floor, Farmington, CT 06030 PH# (860) 679-2795

RECORD OF CASH RECEIVED/REMITTANCE ADVICE SELF PAY/COLLECTIONS

T00#	ADMISSION #	PATIENT NAME	CARDHOLDER (If same as patient leave blank)	Amount Per Visit	Total Amount CREDIT CARD
T01091xxx	7640xxx	MALATI DOE		$122.73	$122.73
T01304xxx	7488xxx	JULIAN DOE	CINDY LIZ DOE	$6.34	$6.34
T01347xxx	6970xxx	CHANELL DOE		$21.51	$100.00
	7111xxx	CHANELL DOE		$78.49	
T01341xxx	7623xxx	KAYLA DOE	GLENDA ROSARIO DOE	$21.73	$21.73
T01472xxx	7537xxx	NATALIYA DOE		$41.00	$41.00
T01198xxx	6851xxx	LUCILLE DOE		$400.00	$400.00
COUNT			TOTALS	$691.80	$691.80

SIGNED : *Benjamin Maysonet*

PLEASE SEND ORIGINAL AND (1) COPY OF THIS FORM TO THE CASHIER

EXTENSION: *x2781* DATE: 02/24/2011

Credit Card total must agree to Credit Card Settlement report from Global Payments machine

- The Collector who receives the Credit Card must "immediately" dispose of the Patients Credit Card information by placing this paper record in a locked shredding bin.
- If the Collector processes a "statement" showing Credit Card Information, the Collector will process the Credit Card, and then cross off the Security 3 or 4 digit#, and cross off the numbers, minus the last 4 digits of the Credit Card#.

ACCOUNT NUMBER:	EXPIRATION DATE:	3 DIGIT # ON BACK OF CARD:	AMOUNT CHARGED:
XXXX XXXX XXXX 1723	09/12	XXX	$440.60

- The Collector will print out the receipts, and attach the statement to the Batch to be submitted at the end of the day to the Cash Posting Department.
- The Collector is to dispose of all Credit Card Information from their desks after processing the transactions. This is to be in compliance with keeping the patient information safe and secure.
- The Collectors' Daily Log (Excel Spreadsheet) should be dated with the same date as the processing date of the transactions in the Global Virtual Terminal.

- The Collection Supervisor will monitor the Collectors for Compliance with the Policies of the University Of Connecticut Health Center/John Dempsey Hospital.

III. COLLECTION PROCESS

- The Collection Staff will use the following methods to contact the patient:

    1) Home telephone number
    2) Place of Employment number
    3) Cell phone number
    4) Relative or other number
    5) Template letter series

- When contacting the patient /guarantor for payment, always identify yourself and the Hospital, make sure you have identified who you are speaking with, and demand payment in full. Always conduct yourself in an appropriate and businesslike manner. Do not discuss any aspect of the patient's medical condition during these conversations.

- The Collection Staff can contact the following persons regarding a patient's outstanding balance:

    1) Patient/Guarantor
    2) A spouse regarding the balance the patient owes or if the patient gives permission to discuss the patients detailed services.
    3) A Power of Attorney assigned to handle the patients' medical bills (proof is required).
    4) A Conservator assigned to handle the patient's medical bills (proof is required).
    5) A patient/guarantor's attorney if a signed HIPAA authorization from the patient/guarantor giving their Attorney the right to discuss the patient's medical bills is provided.
    6) Interpreters who assist the patient if the patient/guarantor is Bilingual.
    7) Relatives or friends of patient/guarantor after they give permission.
    8) Other Third Parties if the patient is deaf or blind after the patient/guarantor gives permission.

- The Collection Staff will use the following tools to skip trace an account when the contact information is outdated:
    1) Use of Town Websites to verify property.
    2) Use the Internet to locate new listings for the patients (Example: 411.com or switchboard.com).

- The Collection Staff must have knowledge of the Privacy Laws & how they

apply. (Example: UCHC policy on privacy; HIPAA (Federal Law); HITECH (Federal Law)).

- The Collection Staff checks assets for balances $2,000+ to determine if the files should be referred to the Connecticut Attorney General's Office or to a collection agency. To check for assets, use town websites or town assessor's offices to verify property ownership and contact listed employers to verify employment status.

- The Collection Staff sends Charity Care Applications to uninsured patients in need of financial assistance. The Collection Staff also reviews the Charity Care Application to make sure the application for assistance is accurate and complete. Once complete, it should be given to the Collection Supervisor for final review for approval or denial.

- The Collection Staff interviews the patient over the phone to see if they qualify for the Brainard/Murphy Fund which is governed by the Hartford Foundation for Public Giving. This program assists patients in paying their medical bills, and who need to protect their assets who meet the fund criteria.

IV. PAYMENT CONTRACTS

A) In-house Budget Plans are to be administered under the following guidelines:

- Payment plans for account balances under $100.00. These must be paid in 2 installments within 60 days.
- All pay plans must require an up-front deposit of 5%-25% and be subject to the following guidelines:

  Balances Between $101 and $500.00 to be paid within 4 months

  Balances Between $501 and $1,000.00 to be paid within 8 months

  Balances Between $1,001 and $2,000.00 to be paid within 12 months

  Balances Over $2,000.00 to be paid 12+ months on the discretion of the Collection Supervisor

- A payment Contract form must be sent to the patient/guarantor for their signature acknowledging acceptance of this agreement. (see attachment A)

If a patient cannot meet the following obligations, he or she may be eligible for a sliding scale discount under a sliding scale arrangement similar to our present Charity Care scale or a Temporary Reduced Budget Plan (***See Section II-B***). This discount would go into effect after the patient met the arrangement. This sliding scale and the eligibility

requirements are updated annually when the Federal Poverty Guidelines are posted by the Federal Government February of each year.

If a patient defaults on their monthly payment twice within a six month period, the account will be referred to a collection agency. Any missed payments must be added to the next month's payment.

If subsequent admissions occur after the terms of the pay plan are agreed to, the monthly installment will be recalculated.

Any patient who does not agree to our terms of payment plans, does not qualify for a discount under a sliding scale, Charity Care or defaults on their payment plan shall have their balance referred to our collection agency for administration.

Payment Contract accounts will receive a monthly statement to remind them of their payment due for which they would send in the stub from their dunning statement with each payment in the return envelope supplied.

Settlements can be done by the Collection Staff up to 20% of the balance due after the patient notifies the staff member of their financial situation. If more than a 20% discount is required, the Collection Supervisor or Patient Access Supervisor can assist the patient with up to a 40% discount. If a discount over 40% is needed, the Director of Patient Financial Services will make the determination if a larger discount is warranted. Payment is due within 7 days of agreement. Detailed notes explaining the discount must be entered on the visit.

B) Temporary Reduced Budget Plans

- Patients that can't make payment in full, make a minimum down payment or make the standard Budget plans, may be eligible for a Temporary Reduced Budget Plan. A deposit should still be demanded from 5% to 25% on a Temporary Reduced Budget Plan but can be waived.
- A Temporary Reduced Budget Plan is good for 6 months. Patients must provide a satisfactory reason why they are unable to pay under the Standard Pay Plan. Once documented in Web IDX, collectors have authority to grant this based on the patients needs

Less than $100.00- minimum to accept is $20/MO.
Between $101-$500- minimum to accept is $25/MO.
Between $501-$1,000- minimum to accept is $25/MO.
Between $1,001- $2,000- minimum to accept is $25/MO.
Between $2,000- $2,499- minimum to accept is $25/MO.
Greater than $2,500+ Collection Supervisor is to review

- A monthly report will be provided to monitor the status of all Budget Plans. Patients who have defaulted on all Temporary Reduced Budget Plans, should be referred to outside collection agencies.

V. SETTLEMENTS

There are occasions when John Dempsey Hospital will negotiate a settlement or discount on a patient's balances when they have no insurance coverage or have a self-pay balance due.
Negotiated settlements are offered as an incentive for quick payment of self-pay balances, to reduce the hospital's accounts receivable and lower collection agency expense. Settlements are not to replace our efforts to collect payment in full on self-pay balances. Before any negotiated settlement is offered, there must be a documented attempt to collect the entire self pay balance, and a reason why the settlement offer is appropriate.
Negotiated settlements can be arranged by the Collection Agency.

Self Pay Definitions

-Meets State of Connecticut definition of uninsured (should be eligible for charity care)

OR

-Self-pay, no insurance coverage

OR

-Balance after insurance payment

Criteria for settlements

- Balances must be over $100.00
  The patient's self-pay balances must be over $100.00 to be considered.
- Only services and charges already incurred are eligible.
  Settlements cannot be negotiated for future services.
- Settlements can be approved for up to 40% of the self-pay balance.
- All settlements exceeding an adjustment of $500 need JDH manager's approval. Any settlement exceeding an adjustment of $1,000 needs JDH Director's approval.
- Payment in full of the remaining self pay balances
  - No adjustment will be made to the account until full payment of the balance that will remain has been received.
  - This payment must be received within 7 business days. With the JDH manager's approval, it can be extended.

Guide lines

% of adjustments	Who can approve
0-20%	Collection Agency
20-40%	Collection Supervisor JDH
40% or greater	Director, Patient Financial Services JDH

VI. PATIENT ACCESS PAY PLANS

- The Patient Access Department of the Hospital will assist in collecting upfront payments from the patients who need assistance in paying the services. The following is the policy of the Department of Patient Access:

    1) JDH – Diagnostic and Surgical Procedures paid in full prior to service 20% discount. The Patient Access Staff must inform patient that this is an estimate. Patient will also receive a 20% discount on balances.

    2) If patient cannot pay in full, collect 50% of the estimated charges this must be collected prior to services. If patient cannot pay 50% of estimated charges, please see Patient Access Supervisor or Director for instructions. In the event Patient Access Supervisor or Director are unavailable, the Patient Access Staff can be advised by Collection Supervisor or Director of Patient Financial Services.

VII. OUTSIDE COLLECTION AGENCIES:

We require our Collection Agencies to do the following processes:

1. Administration of payment plans that we refer to them.
2. Send out dunning statements to patient/guarantor..
3. Regular collection activities.
4. Usage of the Hospital A/R automated system to collect information if available.
5. Settlements up to 20% to assist in collecting accounts without contacting the Hospital Collection Supervisor. If over 20% settlement is needed, the Collection Agencies contact the Collection Supervisor who will in turn make a determination of how much discount will be given. If over 40% is required, the Director of Patient Financial Services makes the determination.
6. The Collection Agencies notifies the Hospital Collection Supervisor in the event the patient wants to file for the Charity Care Program.

We require the collection agency be fully automated and computerized so they can swap and download diskettes or via secured download using other software with us.

VIII. MISC

A Credit and Collection policy should be available and given to patients in admitting for inpatient bills and in the following units:

- Rehab Services
- Day surgery
- Psych clinic and day treatment center

We have placed on the statement dunning notice 1, 2, 3 & 4 that reflects the acceleration of the dunning to each patient. These statements coincide with the C & C policy.

The sliding scale are approved or denied by the Collection Supervisor for Psych Clinic as well as the Outpatient Therapy services (OPS). The Collection Staff will review and adjust any patient balances that were approved for sliding scale.

The Collection Supervisor will review and approve all Charity Cares, and do the proper adjustments as needed up to $4,999.99.

The Director of Patient Financial Services will review all Charity Care applications above $5,000.00+ with the Collection Supervisor adjusting the balances accordingly.

(Example A)

John Dempsey Hospital
Payment Contract

:_____

:_____

:_____

Date:_____

Re: Patient Name:_____ **MRN:**_____

Date Of Service:_____ **Balance Due:_____**

Dear_____:

This is to confirm our conversation of _____ regarding your monthly payment.
Your deposit of 25% is $_____ and is due in our office by_____.
Your monthly installment will be $_____ is due by the_____ of each month, beginning on_____. This contract will be reviewed every 6 months to determine if arrangement plan is appropriate.

Payment should be sent to:

John Dempsey Hospital
263 Farmington Ave. Bldg #18
P.O. Box 4034
Farmington, Ct. 06030-4034

In order to credit your account appropriately, please include your account(s) number on the check or money order.

If for any reason you are unable to keep this payment schedule, you must notify me immediately. Failure to do so could result in further collection action on this account.

Should you have any problems or questions, please feel free to call me directly at (860)679-_____ Monday through Friday 8:00 to 4:15 p.m.

Sincerely,

Patient Financial Services Dept.

John Dempsey Hospital
OHCA FY 2013 Annual Reporting
Report 15 - Uncompensated Care and Bad Debt Policies (Free Care and Bad Debt)

2013 POVERTY LEVEL GUIDELINES

Federal Income Poverty Guidelines as published in the Federal Register on January 1, 2013

Family Size	% of Poverty Level	100%	101% 125%	126% 150%	151% 175%	176% 200%	201% 225%	226% 250%
	% of Discount of charges	**42.50%**	**42.50%**	**42.50%**	**42.50%**	**42.50%**	**42.50%**	**42.50%**
	Charity Care Discount	**100%**	**84%**	**70%**	**56%**	**42%**	**28%**	**14%**
1	Total Household Income Up to	$11,490	$14,363	$17,235	$20,108	$22,980	$25,853	$28,725
2	Total Household Income Up to	$15,510	$19,388	$23,265	$27,143	$31,020	$34,898	$38,775
3	Total Household Income Up to	$19,530	$24,413	$29,295	$34,178	$39,060	$43,943	$48,825
4	Total Household Income Up to	$23,550	$29,438	$35,325	$41,213	$47,100	$43,943	$58,875
5	Total Household Income Up to	$27,570	$34,463	$41,335	$48,248	$55,140	$62,033	$68,925
6	Total Household Income Up to	$31,590	$39,488	$47,385	$55,283	$63,180	$71,078	$78,975
7	Total Household Income Up to	$35,610	$44,513	$53,415	$62,318	$71,220	$80,123	$89,025
8	Total Household Income Up to	$39,630	$49,538	$59,445	$69,353	$79,260	$89,168	$99,075

Add each add'l person $4,020