GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

Please return to :
JIM STOUGHTON
PATIENT FINANCIAL SERVICES
ROOM 1-279
WATSON PAVILION
GREENWICH HOSPITAL
5 PERRYRIDGE ROAD
GREENWICH, CT 06830

INSTRUCTIONS TO COMPLETE APPLICATION FOR FINANCIAL ASSISTANCE

Please return the completed application and **ALL** documentation to the address above.

- **MAKE COPIES**: We keep the documents in our records, please **PROVIDE COPIES** and keep the originals.

- **EXPLANATION OF MISSING DOCUMENTATION**: If for any reason you are not able to provide all the documents listed, please **EXPLAIN IN WRITING** the reason(s). You may use a separate piece of paper.

- **FINANCIALLY DEPENDENT PATIENTS**: If the patient is claimed as a dependent on the parent's or other person's taxes return, we will need the information of the person who is financially responsible for the patient.

- **INCOMPLETE APPLICATIONS**: Your application may be denied if not returned by the return date will ALL of the appropriate documentation.

- **ONLY FOR HOSPITAL BILLS**: The assistance is **ONLY** for Greenwich Hospital bills. It does NOT apply to bills from physicians or any other medical providers.

- **PROCESS**: Your application will be presented to the hospital's Free Bed Funds committee, which meets once a month (usually at the end of the month). Written notification of the committee's decision is mailed to the applicant a few days after the decision is made.

QUESTIONS? If you have questions or need assistance with the application, please call (203) 863 3013 to speak with a Patient Financial Counselor.

Para asistencia en Español, (203) 863 3012.

DOCUMENTATION NEEDED FOR FINANCIAL EVALUATION

- ✓ **Latest Federal Income Tax form**: first two pages of Federal 1040 form, schedules B, C, and E (if filed) and all 1099 forms. We DO NOT need state income tax forms.
- ✓ **Last two pay stubs of patient and spouse**: showing gross payment and deductions.
- ✓ **Copies of ALL PAGES of the latest monthly bank account statements** (one for each account), and/or investment statements
- ✓ **Written verification of any other income**: including any deposits in bank accounts that exceed stated income.
- ✓ **Copies of latest utility bills, mortgage or rent receipt.**
- ✓ **Copies of any other bills that are a significant expense to you.**
- ✓ **Copies of loans or credit card statements if exceeding $500**

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5 PERRYRIDGE ROAD
GREENWICH, CT 06830

APPLICATION FOR FINANCIAL ASSISTANCE

- Please return the completed application and **all** documentation to the address above by:

_____.

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc) which may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the Hospital the amount recovered for hospital charges.

If any information I have given proves to be untrue, I understand the Hospital may re-evaluate my financial status and take whatever actions become appropriate.

Date of request _____

Applicant's signature_____

FOR INTERNAL USE ONLY

Date received _____

Name of Hospital Representative_____

MO_____

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

APPLICATION/DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE INCLUDING HOSPITAL BED FUNDS

Patient name:		**Date of birth:(MM/DD/YY)**	**S.S. #**
Address:	Town	State	Zip code
Home Telephone #	**Sex** M____ F____	**Marital Status:** Married ____ Single___ Divorced___ Widow(er)___ Separated ___ Other: _____	
Present or last employer:	**Address:** Town	State	Zip Code
Employment date:(MM/DD/YY)	**If terminated, date(MM/DD/YY)**	**Telephone #**	
American citizen: Yes____ No ____ If no, Alien status: _____		**Are you a green card holder: Yes ____ No ____**	
Spouse/next of kin name:	**If next of kin, relationship**		
Address:	Town	State	Zip code
Present or last employer:	**Address:** Town	State	Zip code
Employment date:(MM/DD/YY)	**If terminated, date:(MM/DD/YY)**	**Telephone #**	
Names and ages of dependent children:			
Income: Patient's weekly pay $	**Spouse's weekly pay $**		
Other Family income (Social Security , unemployment, VA, child support, alimony, pension, interest, dividends, rental income, etc) **List source:** **Amount $ _____**			
List source: **Amount $**			
Assets: (home, property, CD, bank acct., motor vehicle, life insurance, etc) **List source:** **Amount $ _____**			
Expenses: rent/mortgage/monthly payment	**Utilities: (average monthly payment)**		
Medical bills currently owed:	**Alimony/child support received monthly**	**Credit cards/loans (name/amount owed)**	
Other bills: (type & amount owed)			
Health Insurance name:	**ID #**		
Group or direct? If group, name:	**Name of insured** ___	**Hospital coverage YES___ NO**	

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

Por favor envíe a :
JIM STOUGHTON
PATIENT FINANCIAL SERVICES
ROOM 1- 279
WATSON PAVILLION
GREENWICH HOSPITAL
5 PERRYRIDGE ROAD
GREENWICH, CT 06830

INSTRUCCIONES PARA COMPLETAR SU SOLICITUD DE AYUDA FINANCIERA

Por favor retorne la solicitud completa y **TODA** la documentación requerida a la dirección arriba anotada.

- **HAGA COPIAS**: el hospital no retorna los documentos presentados con su solicitud, **HAGA copias** y conserve los originales de aquellos documentos que pueda necesitar en el futuro.

- **EXPLICACION ESCRITA DE CUALQUIER INFORMACION QUE LE HAGA FALTA**: Si por alguna razón no puede envíar alguno de los documentos solicitados, **EXPLIQUE POR ESCRITO** las razones por las cuales no puede hacerlo. Lo puede hacer en Inglés o Español en una página adicional.

- **PACIENTES DEPENDIENTES ECONOMICAMENTE DE OTRA PERSONA**: Si el paciente depende económicamente y se encuentra incluído en la declaración de impuestos de otra persona, necesitamos la información del responsable financiero.

- **ENVIE LA MAYOR CANTIDAD DE INFORMACION**: El comité toma la decisión sobre su solicitud en base a la información por Usted suministrada. Por favor explíque las circunstancias por las cuales necesita la ayuda financiera. Lo puede hacer el reverso de esta página o en una hoja por separado.

- **SOLICITUDES INCOMPLETAS**: Su solicitud puede ser negada si no es retornada en la fecha requerida con la documentación solicitada.

- **SOLO PARA FACTURAS CON EL HOSPITAL**: La asistencia financiera es **UNICAMENTE** para facturas del hospital. SI Usted tiene facturas de otros proveedores médicos, esta solicitud **NO** las cubre.

- **PROCESO**: Su solicitud será presentada al comité de asistencia , el cual se reune una vez al mes (usualmente al final del mes). Notificación escrita de la decisión del comité le será enviada por correo unos días despúes de la reunión.

PREGUNTAS? Si Usted tiene alguna pregunta o necesita ayuda con la solicitud puede llamar al número (203) 863 3012.

DOCUMENTACION REQUERIDA PARA EVALUACION FINANCIERA

- ✓ **Ultima declaración federal de impuestos**: las primeras dos páginas de la declaración federal, forma 1040, los apéndices B, C, y E (si Usted los ha declarado). NO necesitamos las formas estatales.
- ✓ **Dos ultimos comprobantes de pago del paciente y/o esposa(o)**: que muestren el pago total y deducciones.
- ✓ **Copias de TODAS LAS PAGINAS del último extracto bancario** (uno por cada cuenta),y/o extractos de inversiones
- ✓ **Verificación escrita de cualquier otro ingreso**: incluyendo depósitos bancarios que excedan el ingreso que Usted demuestra en sus comprabantes de pago.
- ✓ **Copias de los últimos recibos de servicios** (agua, luz, etc) , hipoteca y/o recibo de pago de renta y cualquier otro pago que sea significativo para Usted.
- ✓ **Copias de extractos de créditos o tarjetas de crédito**.

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

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GREENWICH, CT 06830

SOLICITUD DE AYUDA FINANCIERA

Por favor, devuelva la solicitud diligenciada y todos los documentos a la dirección anotada,

antes de _____.

Yo, _____, Certifico que la información provista es exacta y en el mejor de mi conocimiento, verdadera .Adicionalmente, realizaré solicitudes de cualquier otra ayuda financiera (Medicaid, Medicare, Seguro médico, etc) las cuales pueden estar disponibles como ayuda para cubrir los gastos hospitalarios. Así mismo, adelantaré las acciones necesarias para obtener estas ayudas y pagaré las cantidades que me hayan sido adjudicadas por estas entidades a los cargos que tenga pendientes con el hospital.

Si se llegara a comprobar que cualquier parte de la información por mi suministrada no es verdadera, entiendo que el Hospital podrá reevaluar mi estado financiero y tomar las acciones correspondientes.

Fecha de la solicitud _____

Firma del solicitante_____

PARA USO INTERNO UNICAMENTE

Fecha de recibo _____

Nombre del representante del hospital _____

MO: _____

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

SOLICITUD PARA DETERMINAR ELIGIBILIDAD DE AYUDA FINANCIERA - FONDOS HOSPITALARIOS

Nombre del paciente:	**Fecha de nacimiento: (MM/DD/YY)**	**S.S. #**
Dirección:	**Ciudad** Estado	Cód. postal
Teléfono casa #	**Sexo** M ____ F____	**Estado civil** : Casado(a) ____ Soltero(a)___ Divorciado(a)___ Viudo(a)___ Separado(a) ___ Other: _____
Ultimo o actual empleador:	**Dirección:** Ciudad	Estado Cod. Postal
Fecha de empleo:(MM/DD/YY)	**Fecha retiro(MM/DD/YY)**	**Teléfono #**
Ciudadano U.S.: Sí____ No ____	**Si no, estado migratorio :** _____	**Tiene tarjeta de residencia: Sí ____ No ____**
Nombre Esposo(a) o pariente:	**Parente, tipo de relación**	
Dirección:	Ciudad Estado	Cód. postal
Ultimo o actual empleador:	**Dirección:** Ciudad	Estado Cód. Postal
Fecha de empleo:(MM/DD/YY)	**Fecha de retiro:(MM/DD/YY)**	**Teléfono#**
Nombres y edades de hijos ,si dependen económicamente del solicitante:		
Ingreso semanal Paciente $	**Ingreso semanal Esposo(a) $**	
Otros ingresos familiares (Seguro Social, seg. desempleo, VA, soporte infantil, alimentos, pension, intereses, dividendos, etc) **Lista de recursos:**	**Cantidad $** _____	
Lista de recursos :	**Cantidad $**	
Activos (finca raiz,CD,cuentas bancarias, vehículos,seguro de vida, etc) **Lista de recursos:**	**Cantidad $** _____	
Gastos: renta/hipoteca/pagos mensuales	**Servicios: (pagos mensuales promedio)**	
Cuentas Médicas pendientes:	**Alimentos/ soporte infantil mensual**	**Tarjeta de Crédito /préstamos (Nombre/cantidad)**
Otros gastos: (tipo y cantidad total)		
Seguro médico:	**ID #**	
Grupo o directamente? Si tiene grupo, nombre:	**Nombre del asegurado**	**Cubrimiento Hospitalario** **SI___ NO ___**

English

YNHHS Summary of Financial Assistance Programs

YALE NEW HAVEN HEALTH

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS

Yale New Haven Health System (YNHHS):
Yale-New Haven Hospital ("YNHH"), Bridgeport Hospital, and Greenwich Hospital (each a YNHHS Hospital)

Yale New Haven Health System understands that it can be difficult for some patients to afford to pay their hospital bills. That is why we have a variety of financial assistance programs designed to help. To learn more or to obtain an application for any of these programs, please contact a financial representative:

- YNHH and Bridgeport Hospital Programs: (203) 688-8860
- YNHH Saint Raphael Campus patients: (203)789-3227
- YNHH Me & My Baby Program patients: (203) 688-5470)
- Greenwich Hospital Programs: (203) 863-3013, or (203) 863-3334 for the Outpatient Clinic Sliding Scale Program

Free Care Program. This program uses funds donated by the community and YNHHS Hospital funds to provide care to those patients who have demonstrated financial hardship.

For YNHH and Bridgeport Hospital, you may be eligible for free care if your family earns less than 2½ times the Federal Poverty Level (the maximum income amounts are listed on the table to the right), *and* you are a Connecticut resident, you apply for State Medical Assistance (Medicaid), and receive a valid written decision from the State. Patients with insurance coverage will be considered for this Program on a case-by-case basis.
For Greenwich Hospital, you may be eligible for free care if your family earns less than 2½ times the Federal Poverty Level, and/or you show financial hardship in paying your hospital bill. You may be required to apply for Medicaid and show denial of such application.

Family size	Maximum Income
1	$28,725
2	$38,775
3	$48,825
4	$58,875
5	$68,925
6	$78,975
7	$89,025
8	$99,075*

**Add $10,050 for each additional family member*

Nominated Free Bed Funds. In some cases, donors select a certain church, individual or entity that can "nominate" specific patients to receive free bed funds. You may be eligible to receive nominated free bed funds to reduce or eliminate your YNHHS Hospital bill if: (1) you have a demonstrated financial need as determined by a fund's nominator; (2) you meet all eligibility criteria to receive funds (each fund has unique criteria); and (3) you are nominated to receive the funds. There are no specific income limits for receipt of nominated free bed funds. Eligibility is determined on a case by case basis by the fund nominators based on guidelines for a given fund. All patients who fill out financial assistance applications will be considered for nominated free bed funds.

Sliding Scale Program. While Connecticut law requires discounts only for uninsured patients at or below 2 ½ times the Federal Poverty Level, the Sliding Scale Programs go much further, lowering hospital bills significantly for patients who (1) have family income less than 4 times the Federal Poverty Level (see the amounts listed on the table to the right), and (2) for *YNHH and Bridgeport Hospital*, do not have any type of health insurance, or for *Greenwich Hospital*, show financial hardship in paying their hospital bill.

Greenwich Hospital Outpatient Clinic. You may be eligible to become a member of the Greenwich Outpatient Clinic which provides care under the Greenwich Hospital Sliding Scale Discount Program if (1) you are a Greenwich resident, and (2) you have family income less than 4 times the Federal Poverty level.

Family size	Maximum Income
1	$45,960
2	$62,040
3	$78,120
4	$94,200
5	$110,280
6	$126,360
7	$142,440
8	$158,520

Catastrophic Sliding Scale Program. This program provides discounts to patients who f*or YNHH and Bridgeport Hospitals*, (1) do not qualify for Sliding Scale; (2) do not have any health insurance; and (3) have hospital bills greater than 10% of their annual family income, or for *Greenwich Hospital* (1) do not qualify for Sliding Scale; (2) have hospital bills greater than 10% of their annual family income; and (3) otherwise show financial hardship in paying their hospital bill.

Me & My Baby Program (YNHH only). This program provides prenatal care, labor and delivery services, and some post-partum care free of charge to those who qualify. You may be eligible if (1) you live in New Haven County; (2) you do not have any type of health insurance; (3) your family earns less than 2½ times the Federal Poverty Level (see maximum income chart for Free Care Program above); and (4) you apply for State Medical Assistance (Medicaid) and receive a valid written decision from the State.

These programs cover emergency and other medically necessary care and apply ONLY to YNHHS Hospital bills. You will receive a written response to each application for assistance. If your application is rejected, you may re-apply at any time. Additional free bed funds become available every year.

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

AVAILABILITY OF HOSPITAL FUNDS

Greenwich Hospital has financial assistance programs and funds available, including hospital bed funds, given to the Hospital to provide care to patients including those who are not covered under, or receive services not covered under, insurance or governmental programs, AND

1. Show compelling hardship or personal circumstances which warrant providing financial assistance, AND/OR
2. Have an income at or below the following levels, which are 250% of the Federal Poverty guidelines:

Family Unit Size	Monthly Income	Annual Income
1	$ 2,394	$ 28,725
2	3,232	38,775
3	4,069	48,825
4	4,907	58,875
5	5,744	68,925
6	6,582	78,975
7	7,419	89,025
8	8,257	99,075
For each additional person add:	838	10,050

Other funds to provide financial assistance to patients are help by outside trustees and are also available. Additional funds may become available annually.

If you think you may be eligible for Hospital funds and want to apply for them, you may request them from the Patient Financial Counselor at (203) 863-3013 who will provide you with an application.

You may also qualify for other kinds of financial assistance such as Medicaid or if you are a resident of the Town of Greenwich, you may be qualified to attend our Outpatient Clinic.

Dependent upon the time we receive your completed application for hospital funds, Greenwich Hospital will make a determination of your eligibility:

1. Either within a reasonable time before your intended service, or
2. Within approximately thirty (30) days.
3. If you are denied hospital funds, you have the option to reapply

The estimated total annual amount of free care available for all these funds is $2,800,000 ($2,300,000 from hospital bed funds and from other charitable funds held by the Hospital and $495,000 from funds held by outside trustees).

Public Law No. 91-348, P.A.03-266
Date October 1, 1991
Revised March 2013

Por favor, vea atras para Espanol

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

DISPONIBILIDAD DE FONDOS PARA HOSPITALARIOS

El Hospital de Greenwich tiene programas de asistencia económica y fondos disponibles, incluyendo fondos para hospitalizaciones. Estos fondos son dados al Hospital para proveer cuidado, entre otros, a pacientes que no tienen cobertura, o que reciben servicios no cubiertos por seguros o programas gubernamentales, y que:

1. Presenten dificultades apremiantes o circumstancias personales que ameriten ayuda financiera, y/o
2. Tengan un ingreso en o por debajo de las Pautas Federales de Ingreso:

Miembros en la Familia	**Ingreso Mensual**	**Ingreso Annual**
1	$ 2,394	$ 28,725
2	3,232	38,775
3	4,069	48,825
4	4,907	58,875
5	5,744	68,925
6	6,582	78,975
7	7,419	89,025
8	8,257	99,075
Por cada persona adicional añada:	838	10,050

Existen otros fondos para proveer ayuda financiera a pacientes, los que se encuentran en Fideicomisos externos y también, están disponibles. Fondos adicionales pueden estar disponibles anualmente.

Si Usted piensa que es elegible para recibir fondos hospitalarios y desea solicitarlos, puede consultar al Consejero Financiero para Pacientes al (203) 863-3013, quien le podrá suministrar una solicitud.

Adicionalmente, Usted puede ser elegible para otra clase de ayuda financiera, tal como Medicaid; o si es residente en el pueblo de Greenwich puede ser elegible para la Clínica para Pacientes Externos.

Dependiendo del momento en que recibamos su solicitud de ayuda financiera debidamente diligenciada, el Hospital de Greenwich evaluará su elegibilidad:

1. En un tiempo razonable, antes de que reciba sus servicios, o
2. Dentro de unos treinta (30) días, aproximadamente.
3. Si se le han negado fondos hospitalarios en el pasado, Usted tiene la opción de volver a hacer la solicitud.

La cantidad total anual estimada para cuidado gratuito disponible para todos estos fondos hospitalarios es de 2,800,000 ($2,300,000 de los fondos para hospitalizaciones y de otros fondos de caridad en poder del Hospital, y $495,000 de fondos en poder de fideicomisos externos).

Ley Pública 91-348, P.A. 03-266
Fecha: 1 de Octubre de 1991
Revisada: Marzo , 2013

Please see reverse side for English

Greenwich Hospital Greenwich, Connecticut 06830	**ADMINISTRATIVE POLICY AND PROCEURE**		
Title: **Billing and Collection: Bad Debt**			Policy #: **A-J:2**
Date Issued: **10/09**	Date Reviewed/Revised:	Approved By: **President & Chief Executive Officer**	Page 1 of 5
Contact: **Director, Patient Accounts**			

PURPOSE:

To ensure that outstanding balances on patient accounts are pursued fairly and consistently by the Hospital and its agents in a manner consistent with its charitable mission.

DEFINITIONS:

"Collection agent" means any person, either employed by or under contract to, the Hospital, who is engaged in the business of collecting payment from consumers for medical services provided by the Hospital, and includes, but is not limited to, attorneys performing debt collection activities.

"*Hospital bed fund*" or "*free bed fund*" means a special donation received by the Hospital to subsidize, in whole or in part, the cost of medical care, including inpatient or outpatient care, incurred by patients at the hospital, whose financial circumstances render them unable to pay their hospital bills.

"*Patient*" means those persons who receive care at the Hospital and the person who is financially responsible for the care of the patient.

"Uninsured patient" means any person who is liable for one or more hospital charges whose income is at or below two hundred fifty percent (250%) of the poverty income guidelines who: (1) has applied and been denied eligibility for any medical or health care coverage provided under the state-administered general assistance program or the Medicaid program due to failure to satisfy income or other eligibility requirements, and (2) is not eligible for coverage for hospital services under the Medicare or CHAMPUS programs, or under any Medicaid or health insurance program of any other 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.

POLICY:

It is the Hospital's policy to treat all patients equitably with respect and compassion, from the bedside to the billing office. The Hospital will pursue patient accounts, directly and through its collection agents, fairly and consistently taking into consideration demonstrated financial need.

PROCEDURE:

A. General

1. In accordance with Connecticut law, before a bill is sent to a patient the Hospital will:

    a. determine (based on information in its possession) (i) if the patient is an uninsured patient and (ii) eligibility for free bed funds; and

    b. notify the patient in writing of this insurance determination and the reasons for the determination.

2. In accordance with Connecticut law, the Hospital will not collect more than the cost of services from an uninsured patient.

3. Each bill and all collection notices from the Hospital, or any collection agent acting on behalf of the Hospital, must include the Hospital's Summary Notice of Free Care Availability.

4. Throughout the billing and collections cycle, the Hospital will provide financial counseling to patients about their Hospital bills and respond promptly to patient's questions about their bills and to requests for financial assistance.

B. Pre-Collections

The Hospital will follow its pre-collection billing cycle in accordance with internal operational processes and practices.

C. Outside Collections

1. The Hospital will seek to maintain written contractual relationships with one or more collection agents for collection of past due accounts that will require compliance with the standards and scope of collection practices set out in this Policy.

2. At the end of the Hospital's internal (pre-collection) billing cycle, outstanding balances may be referred to an approved outside collection agent under the following guidelines:

(i) Hospital has billed all third-party payers that may, based on hospital's records, be responsible for paying the claim;

(ii) Hospital has provided patient information on how to arrange for a payment plan if the patient cannot afford to pay the entire bill at once and patient has not qualified for, arranged for, or complied with a payment plan;

(iii) Hospital has notified patient that it has free bed funds and other free or discounted care for which the patient may be eligible;

(iv) (a) No financial assistance application has been completed that establishes the patient's eligibility for hospital bed funds or other financial assistance nor is an application in process, or (b) patient has applied and qualified for partial financial assistance, but has not paid his/her responsible part then the ineligible portion of the account may be referred for collection;

(v) A representative of the Hospital's Finance Department or a Turnover Expeditor concludes, based on the results of an internal review and in accordance with the Hospital's eligibility criteria for its financial assistance programs, that the patient has the financial ability to pay for all or a portion of his or her bill; and

(vi) The referral is reviewed and approved by the Credit & Collections staff under the direction of the Manager, Credit & Collections and using criteria & procedures permitted by the Director of Patient Accts and/or the Sr. VP, Finance.

3. If at any point in the debt collection process, the Hospital, including any employee or agent of the Hospital, or a collection agent acting on behalf of the Hospital, receives information that a patient is eligible for hospital bed funds, free or reduced price hospital services, or any other program which would result in the elimination of liability for the debt or reduction in the amount of such liability, the Hospital or collection agent will promptly discontinue collection efforts and, if a collection agent, refer the account back to the Hospital for determination of eligibility. The collection effort will not resume until such determination is made.

4. The Hospital will annually file a debt collection report with the Office of Health Care Access as required by Connecticut law.

RESPONSIBILITY:

Sr. VP, Finance, Director of Patient Accounts, and all Credit & Collections Department Staff

REFERENCES:

Conn. Gen. Statutes §19a-673 and §19a-673(a) – (d)
Fair Debt Collection Practices Act
Connecticut Not-For-Profit Acute Care Hospital Voluntary Guidelines for Debt Collection
AHA – Statement of Principles and Guidelines - Hospital Billing & Collection Practices

RELATED POLICIES:

Administrative Policy & Procedure A-A 18 - Questions Regarding Bills for Patient Care
Charity Care Policy

Exhibit A

STANDARDS & SCOPE OF COLLECTION PRACTICES

1. Prior approval of legal action required.

   Collection agents must obtain written approval from the Hospital's Director of Patient Accounts, and/or the Senior Vice President, Finance or his or her designee, prior to the initiation of any legal action concerning a referred account.

2. Property Liens & Foreclosures.

   Liens on personal residences are permitted only if:

   (i) The patient has had an opportunity to apply for free bed funds and has either failed to respond, refused, or been found ineligible for such funds;

   (ii) The patient has not applied or qualified for other financial assistance under the Hospital's Charity Care Policy, including sliding scale discounts to assist in the payment of his/her debt, or has qualified, in part, but has not paid his/her responsible part;

   (iii) The patient has not attempted to make or agreed to a payment arrangement, or is not complying with payment arrangements that have been agreed to by the Hospital and patient;

   (iv) The aggregate of account balances is over $1000 and the property(ies) to be made subject to the lien are at least $200,000 in assessed value; and

   (v) The lien will not result in a foreclosure on a personal residence. Except in unusual circumstances (*e.g.* where there is evidence of an ability to pay, multiple homes or properties, or the existence of significant assets), the Hospital will not pursue foreclosures for property liens.

3. Wage Garnishments.

   Garnishments of wages are permitted only if:

   (i) The patient is not an uninsured patient;

   (ii) The criteria in (i) – (iii) above under Property Liens are met;

   (iii) A court determines that the patient's wages are sufficient for garnishment and enters a judgment against the patient; and

   (iv) The Hospital has notified the patient in writing of the foregoing.

(v) Wage garnishments, if approved, will only apply to account balances over $500. Additionally, any State Marshall fee for administering the wage garnishment will be absorbed by the Hospital as a cost of collection. No interest will accrue on wage garnishments.

4. Bank Executions.

All bank executions, in addition to pre-approval, require special review by the Hospital for verification that the execution will not cause undue financial hardship on the patient. If this cannot be determined, no bank execution will be ordered.

5. Writs of Capias.

The Hospital will not pursue and will not initiate a writ of capias (*i.e.*, a petition to have a debtor arrested as a result of a debt collection activity). The Hospital may ask for examinations of patients but the Hospital itself will specifically indicate that the Hospital does not request any writ of capias.

6. Interest and Court Costs.

Interest will be allowed to accrue on accounts after legal court judgment is received. Interest will accrue at the current statutory rate. The Hospital will not allow interest to accrue greater than 50% of the account balance. If the principal is paid in full, the Hospital will waive payment of interest. Court costs will be assumed by the Hospital as a cost of collections and not charged to the patient.

7. Credit Reports.

No accounts or account activity will be directly reported to Credit Bureaus or rating agencies. Credit Bureaus may obtain information from court records.

Greenwich Hospital

OVERVIEW OF FINANCIAL ASSISTANCE PROGRAMS FOR HOSPITAL SERVICES

I. PURPOSE:

Greenwich Hospital ("GH" or the "Hospital") recognizes that many patients may be uninsured, may not have adequate insurance or may otherwise lack the financial resources to pay for quality health care services without financial assistance. Consistent with its mission, the Hospital is committed to assuring that a patient's ability to pay will be considered carefully when settling and or seeking amounts due for health care services.

In recognition of the Hospital's role in helping those in need of financial assistance, the Hospital has established the GH Financial Assistance Programs for Hospital Services ("the Programs"). These Programs include free care policies, clinic sliding scale discounting policies, prompt pay discount, and certain billing/collection policies each separately described in specific policies.

The objectives of the Programs are to:

- Maintain a humane environment for our patients and their families;
- Assist patients in gaining access to government insurance programs;
- Provide clear information regarding the Programs;
- Ensure easy and timely access to the Programs.
- Consistently apply the Programs to all patients;
- Apply fair and equitable business practices with respect to the collections of bills for patient services; and
- Comply with all applicable laws, rules and regulations and other binding obligations of the Hospital.

All patients will have the option to apply for government or Hospital financial assistance programs based on financial need.

II. POLICY:

A. General Scope.

1. The Programs apply to Hospital inpatient, outpatient and ancillary services billed by the Hospital.

2. The Programs **apply generally to**:
   - Uninsured patients (as defined by CT Public Act 03-266).
   - Patients with no insurance coverage.
   - Non-covered services (as determined by the patient's third party payer benefits) that are medically necessary.
   - Under-insured patients with significant co-payments and deductibles.
   - Charges incurred after patients' exhaustion of third party payer benefits.

3. The Programs **generally do not provide for**:
   - Routine waiver of deductibles, co-payments and co-insurance imposed by third party payers on Hospital claims.
   - Private room or private duty nurses.
   - Services that are not medically necessary, such as elective cosmetic surgery.
   - Other fees that may not be charged directly by GH (e.g., guest food trays, gourmet meals, private room charges).

4. The patient will generally be ineligible for some or all financial assistance if any of the following occur:
   - It is determined that false information materially related to financial eligibility and/or status was provided by the patient or responsible party during the application or billing and collection process.
   - The patient or responsible party fails to apply for government insurance programs, and such an application is an eligibility requirement for certain types of assistance in the Programs.
   - The patient or responsible party fails to provide information necessary to complete the eligibility process.

5. GH reserves the right to evaluate a patient's eligibility on a case-by-case basis, especially where complex medical, scientific or financial situations exist.

B. Access to Information.

Patients will obtain information on eligibility for government or Hospital programs from information distributed by the Hospital.

Patients will be alerted to the Financial Assistance Programs in a number of ways, including notices in English and Spanish posted in appropriate locations in the Hospital, a summary of free care availability and information on how to apply for free care (referred to as the "Hospital's Notice of Availability of Funds"), information distributed via mail and / or in the Hospital's admission package, and information on the Hospital's web site. Information will also be provided when direct inquiries are made to GH. There is also access to a translation telephone.

The Hospital will provide notice and information in a manner that (a) complies with the requirements of law, including Connecticut law concerning hospital funds, and (b) is designed to make information easily available and accessible to all patients.

All patients will have access to information regarding estimated charges for particular services or actual charges for hospital services that have been provided.

C. Summary of Financial Assistance Programs.

1. Free Care Funds.

The Hospital has various Free Care Funds to assist those patients who meet the specific criteria and are unable to pay for services rendered.

The Hospital may also have other funds that have been designated by GH to provide free care.

Additional information regarding these funds is contained in the Hospital's Policy for Free Care Funds. See **Exhibit C(1)** attached.

The Hospital will use a free care funds application ("Application") to assess eligibility for Free Care Funds and a Outpatient Department financial assessment application to assess eligibility for the Clinic Sliding Scale Discounting Programs.

2. Clinic Sliding Scale Discounting Programs.

The Hospital offers a Clinic Sliding Scale Discounting Program for eligible patients who may meet the criteria in the Policy for Free Care Funds.

Additional information regarding this program is contained in the Hospital's Sliding Scale Discounting Program. See **Exhibit C(2)** attached.

3. **Extended Payment Plans.**

The Hospital offers alternative payment arrangements for eligible patients.

Additional information regarding this program is contained in the Hospital's Alternative Payment Arrangement Policy. See **Exhibit C(3)** attached.

4. **Waiver of Co-Pays, Deductibles or Spend Down Requirements.**

The Hospital, in certain qualifying circumstances, offers waiver of co-pays, deductibles or spend down requirements.

Additional information regarding this program is contained in the Hospital's Alternative Payment Arrangement Policy. See **Exhibit C(4)** attached.

5. **Financial Screening / Information.**

A patient financial counselor will generally perform a financial screening for inpatients with payment obligations not covered by insurance or other means for the purpose of (a) determining the patient's potential eligibility for financial assistance in connection with any unpaid balances and (b) encouraging patients to apply for such assistance.

D. Credit, Collections and Bad Debt.

The Hospital has adopted policies and procedures relating to credit, collections and bad debt.

Additional information regarding this program is contained in the Hospital's Credit, Collections and Bad Debt Policy. See **Exhibits D and D1** attached.

E. Free Care Funds Committee.

1. **Purpose.**

The Programs will be overseen by a management oversight committee ("Committee"). The Committee will, among other oversight responsibilities, review the case of any patient who may not qualify for a specific Financial Assistance Program, but nevertheless may demonstrate compelling hardship or personal circumstances which warrant financial assistance. The Committee will also review financial assistance requests from patients who are insured, but demonstrate financial hardship in paying co-payments or deductibles.

2. **Composition of Committee.**

The Committee will be chaired by a Senior Vice President of the Hospital. Additional Committee members may include senior management, patient financial services representatives, patient relations representatives, finance and medical staff liaisons as needed. The Committee will meet at least monthly or more frequently, if necessary.

3. Operating Protocols.

Patient accounts may be referred to the Committee for review by Patient Financial Services, Patient & Guest Relations Representatives, or other appropriate referral sources. In general, the Committee will review patient accounts that do not meet the standard eligibility requirements for the various Financial Assistance Programs.

Typical referrals to the Committee will include:

- Insured patients with co-payments and deductibles that present financial hardship.
- Self-pay patients with income / assets over the poverty income levels with a significant bill that presents a financial hardship.
- Insured patients who have exhausted insurance benefits or maximum coverage amounts with a significant bill that presents financial hardship.
- Medicaid enrollees with a Medicaid spend down and demonstrated financial hardship.

The Committee will typically deny financial assistance requests for the following situations:

- Financial hardship caused by the intentional failure of a patient to follow through With: a) medical advice, or b) health plan requirements such as payment of premium, notification of admission, or other requirements outlined in the patient's Subscriber Certificate.

The Committee will maintain minutes of meetings and will communicate findings to the appropriate departments as well as writing to the affected patient.

F. Accounting and Reporting of Financial Assistance Programs.

1. The Hospital's financial department will collect and distribute information to senior management regarding these Programs on at least an annual basis. This information may include, but is not limited to:

- Number of cases referred;
- Number of cases processed;
- Number of cases determined eligible for and referred to government insurance programs;
- Number of Free Care Applications distributed;
- Number of Free Care Applications received (complete and incomplete), accepted and rejected and reasons for rejection; and
- Average time required to process Free Care Applications from the date of receipt of the completed application.

2. A sample spreadsheet showing the reporting format for the above information will be prepared for review and approval by a financial assistance oversight committee.

3. The Finance and Audit Committee of the Board of Trustees of the Hospital will be provided at least annually with a report concerning the status of these Programs.

Revised 03/17/08

Exhibit C1

Greenwich Hospital
Policy for Free Care Funds

I. PURPOSE:

To establish the policy for the use of funds that have been donated to Greenwich Hospital ("GH" or the "Hospital") and other funds that may from time to time be designated by the Hospital to provide free care or charity care. This policy is in addition to the Hospital's other policies related to free care and / or charity care.

The policies and procedures described in this policy are subject to applicable laws, rules, regulations and any applicable agreements, orders, writs, decrees, indentures, trusts or other obligations to which the Hospital is a party or with which the Hospital must comply.

II. POLICY:

A. General Statement of Need.

The Hospital has received charitable contributions including contributions to the Hospital's endowment that are restricted by the donor in a manner limiting their use to the provision of free care or free beds to patients (hereinafter referred to as "Free Care / Free Bed Funds").

Some of the donated funds contain additional restrictions (e.g., home address of patient, church, nominator, etc.). Other funds have no additional restrictions.

The Hospital may if the Hospital so chooses from time to time establish a spending policy with respect to the distribution of these Free Care Funds.

In addition, the Hospital may from time to time determine that such funds are insufficient to satisfy the need for such funds and in such case the Hospital may provide additional free care to patients from the Hospital's operations (hereinafter referred to as "Hospital Designated Free Care Funds").

The Free Care / Free Bed Funds and any Hospital Designated Free Care Funds are collectively referred to as "Free Care Funds."

B. Notice.

The Hospital will provide notice and information to patients about Free Care Funds in a number of ways, including posting notices in appropriate locations in the Hospital; ensuring the availability of a one-page summary description of Free Bed Funds and how to apply for them (referred to as the "Hospital's Notice of Availability of Funds" document); providing individual written notice to patients; and making available written information in other forms that may be helpful to patients.

The Hospital will provide notice and information in a manner that both (a) complies with the requirements of applicable law, including applicable Connecticut law concerning hospital bed and other funds, and (b) is designed to make information easily available and accessible to patients.

The Hospital may develop a more detailed policy and procedure specifically describing how notices and information will be provided.

C. **Eligibility for Donated Free Bed Funds with No Specified Nominator.**

The Hospital has Free Care Funds where the historic dollar value is restricted and the net appreciation and income are available to support free care and or free beds for patients unable to pay, but no specific nominator is named. If the Hospital has adopted a Hospital Endowment Spending Policy, then the allocation of these funds may be based on such Hospital's Endowment Spending Policy.

These Free Care Funds will be available only to patients with no specified nominator after all possibilities of third party reimbursement have been exhausted. The Hospital may require that Patients applied for City and State assistance, and thereafter provide to the Hospital formal documentation showing denial of such applications.

The Hospital requests appropriate documentation to verify eligibility.

In addition, the Hospital, at its discretion and on a case by case basis, may provide Free Funds to patients with insurance, assuming they satisfy the other criteria outlined above and there are no other prohibitions on them receiving such assistance.

If the patient is insured by a governmental program (Medicare, Medicaid or Tricare) or a private insurer, the Hospital will consider requests for Free Funds for co-pays, deductibles, and/or spend-downs on a case by case basis. If granted, these amounts will be relieved at the amounts determined under the contract or program in question.

In addition, the Hospital will consider requests for Free Funds when a patient's insurance or maximum coverage benefits have been exhausted. In making these decisions, the Hospital will consider medical and financial hardship. The Hospital may also choose to provide Free Funds for only a portion of the request, if in the Hospital's judgment, providing Free Funds for the entire request would adversely affect other applicants who meet the qualifications, but are without insurance (and thus may carry a larger debt).

D. Eligibility for Donated Free Bed Funds with Geographic or other Additional Restrictions but no Specified Nominator.

Patients must fulfill the above referenced eligibility guidelines for "Donated Free Bed Funds with No Specified Nominator", and reside in the specific geographic location dictated by the original gift or meet the other additional eligibility restrictions contained in the original gift.

E. Eligibility for Greenwich Hospital's Designated Free Care Funds.

If (a) Free Care Funds with no nominator or other special restriction have been exhausted up to any approved annual endowment spending policy limit, and (b) there are patients otherwise eligible for Free Care Funds who do not meet the restrictions for eligibility for any available restricted Free Care Funds, the Hospital may determine to provide additional free care to patients from Hospital Designated Free Care Funds, to the extent that such funds have been determined to be available in light of the Hospital's current and future financial needs. Patients must nonetheless fulfill the eligibility guidelines for "Donated Free Bed Funds with No Specified Nominator" to be eligible for free care designation from Hospital Designated Free Care Funds.

The Hospital may determine to also make available additional free care funds from operations for other types of requests where the patient demonstrates a compelling hardship or personal circumstances which warrant providing financial assistance.

F. **Eligibility for Donated Funds Restricted to Use by an Outside Nominator.**

The Hospital has Free Care Funds where the historic dollar value is restricted and the net appreciation and income are available to support free beds for patients unable to pay and a nominator is named. The allocation of the available funds may be based on an endowment spending policy, if one has been established by the Hospital.

The Hospital will notify nominators at least annually of the status of Free Care Funds for which they have a nominator role. The nominator may request the use of Free Care Funds for any eligible patient who meets the guidelines for a given fund. Each nominator will receive, at least annually, a report of Free Care Funds utilized by patients (subject to applicable rules and regulations relating to the confidentiality of patient information). Nominators may request that unused funds be held for use in a subsequent year for their previously stated purposes or, to the extent the nominator has such power, the nominator may designate any remaining funds for a particular fiscal year or other period to be used by the Hospital for general free care purposes. In addition, the Hospital may award funds in cases in which the donor has specifically provided that the Hospital has the power to award the funds if the nominator fails to do so.

G. **Accounting of Free Care Funds.**

1. **For donated Free Care Funds with no specified nominator and donated Free Care Funds with geographic or other additional restrictions but no specified nominator:**

If Free Care Funds are to be made available for a patient from such a fund, then the fund will be billed for the services and the bill will be an amount equal to the cost for such services.

2. **For Hospital Designated Free Care Funds:**

If Free Care Funds are to be made available for a patient from such a fund, then the fund will be billed for the services and the bill will be an amount equal to the charges for such services.

3. **For donated Free Bed Funds restricted to Use by an Outside Nominator:**

If Free Care Funds are to be made available for a patient from such a fund, then the fund will be billed for the services and the bill will be an amount equal to the charges for such services.

Revised 03/17/08

GREENWICH HOSPITAL
YALE NEW HAVEN HEALTH

GREENWICH HOSPITAL

2013 OUTPATIENT CENTER FEE SCALE

Family Size	Federal Poverty Level	Clinic Eligibility 200% of FPL	Clinic Eligibility 201-250% of FPL	Clinic Eligibility 251-400% of FPL
	(Annual)	**Level A**	**Level B**	**Level C**
1	$11,490	$22,980	$22,981-28,725	$28,726-45,960
2	15,510	31,020	31,021-38,775	38,776-62,040
3	19,530	39,060	39,061-48,825	48,826-78,120
4	23,550	47,100	47,101-58,875	58,876-94,200
5	27,570	55,140	55,141-68,925	68,926-110,280
6	31,590	63,180	63,181-78,975	78,976-126,360
7	35,610	71,220	71,221-89,025	89,026-142,440
8	39,630	79,260	79,261-99,075	99,076-158,520
For families/households with more than 8 persons, add $4,020 for each additional person.				

**Effective April 1, 2007, we stopped collecting any co-pays from those patients whose financial status is categorized up to 200% of the Federal Poverty Level (Level A).

No fees will be collected for most services at Greenwich Hospital (Level A).
In order for patients to get the benefit of this free care
all services must be ordered or arranged through the Outpatient Center.

Medicare patients who meet Federal guidelines may be eligible for a reduction in co-payment and deductible amounts. These patients must schedule a financial evaluation to determine eligibility.

Outpatient Center Membership must be renewed on an **Annual** Basis.
Please call 863-3409 to schedule an appointment.

Contacts: Outpatient Center – Clinic Registration & Renewal Fee Questions - 863-3334
Credit Specialist – Payment Arrangements, Hospital Fund Applications - 863-3013

Please see reverse side for Fees

Updated April 1, 2013

FEES			
	Level A	**Level B**	**Level C**
Outpatient Center Fee	$0	$25.00 per visit	$25.00 per visit
Behavioral Health Fee	$0	$15.00 per visit	$15.00 per visit
Off-site MDs Fee (includes ENT, Ophthalmology, Cardiology, etc.)	$0	$25.00 per visit	$25.00 per visit
Emergency Room	$0	$35 per visit	$35 per visit
OB Observation	$0	$25	$25
Radiology	$0	$20 per exam	$20 per exam
Nutrition Consult	$0	$20 per visit	$20 per visit
Nutrition Psychology consult	$0	$15 per visit	$15 per visit
Geriatric Assessment	$0	$20 per visit	$20 per visit
Stress Test	$0	$20	$20
Sleep Study	$0	$20	$20
PT/OT/ST	$0	$10 per visit	$10 per visit
Gero-Psychiatry	$0	$10 per visit	$10 per visit
ARC- Outpatient	$0	$10 per visit	$10 per visit
ARC-Detox	$0	$750 per inpatient stay	$750 per inpatient stay
Radiation Therapy	$0	$10 per visit	$10 per visit
Chemotherapy	$0	$10 per visit	$10 per visit
Lab	$0	No Fee	No Fee
Acupuncture	$0	Self-Pay	Self-Pay
IDAP	$0	$10 per visit	$10 per visit
Hyperbaric	$0	$25 per exam $35 per treatment	$25 per exam $35 per treatment
Influenza Vaccine	$15	$15	$15
Pneumococcal Vaccine	$25	$25	$25
For questions on any additional fees please contact the Outpatient Center			

Inpatient Services & Ambulatory Procedures			
Clinic patients are eligible for a reduction on their inpatient and ambulatory services as long as they are medically necessary and are referred by a physician through the Outpatient Center. **Elective procedures or services referred by private physicians cannot be reduced.** The current discounted rates are:			
	Level A	**Level B**	**Level C**
Ambulatory Services	$0	$250.00 per procedure	$250.00 per procedure
Inpatient Services	$0	$750.00 per admission per patient	$750.00 per admission per patient
Inpatient Services - Maternity	$0	$750.00 per admission (regular delivery)	$750.00 per admission (regular delivery)
		$850.00 per admission (C-section)	$850.00 per admission (C-section)

EXHIBIT C2

GREENWICH HOSPITAL

Financial Assistance/Charity Care Policy: Clinic Sliding Scale - Discounting Program

I. PURPOSE:

The purpose of this policy is to establish a policy for providing financial assistance under a sliding scale discounting program to uninsured clinic patients who are determined, under the Hospital's eligibility criteria, to lack the ability to pay for care at full charges.

Greenwich Hospital (the "Hospital") is guided by a mission which includes the provision of high quality care to all patients, including those who cannot pay for all or part of the essential care they receive at the Hospital. The Hospital is committed to treating all patients with compassion, from the bedside to the billing office, and including through payment and collection efforts. Furthermore, the Hospital is committed to advocating for expanding access to health care coverage.

The Hospital will maintain financial aid policies that are consistent with its mission and values and take into account an individual's ability to pay for medically necessary health care services.

In addition to free care provided under this clinic sliding scale discounting program, free care is also provided to uninsured and insured patients in accordance with the Hospital's Policy for Free Care Funds. See the Hospital's separate policy regarding Free Care Funds. The Hospital also provides relief and assistance to other patients pursuant to policies regarding the waiver or reduction of (a) co-payments, (b) deductibles and / or (c) Medicaid spend-down requirements on a case-by-case basis determined on grounds of medical and financial hardship.

II. POLICY:

A. General Statement of Need – Free Care distinguished from Charity Care Defined.

Recognizing its charitable mission, it is the policy of the Hospital to provide a reasonable amount of its services to eligible patients that do not have the ability to pay for care at full charges.

Free care generally involves cooperative efforts among the Hospital and the patient and / or the patient's family pursuant to which free or reduced bills are established for the patient's services.

Charity care is applied to an account when the patient and spouse (or both parents, if the patient is a dependent) are unemployed AND do not own property. Screening for employment and property ownership is done at the end of the usual billing cycle but before the account would be assigned to a collection agency. The only accounts currently screened are those with a balance of $1,000 or greater. Accounts under $1,000 are treated in the same manner if the patient applies for Free Care Funds.

B. Notice.

The Hospital will provide notice and information to patients about the availability of free care under the clinic sliding scale discounting program in a number of ways, including by describing and / or referencing this policy on the Hospital's one page summary description of free care funds and other free or reduced care policies (also referred to as the "Notice of Availability of Funds" document).

The Hospital will provide notice and information in a manner that complies with the requirements of law and is designed to make information easily available and accessible to patients.

The Hospital may develop a more detailed policy and procedure specifically describing the manner in which notices and information will be provided.

C. Eligibility for Clinic sliding Scale Program:

1. Generally. As noted above, the Hospital provides care through the clinic sliding scale discounting programs to uninsured patients who do not have the ability to pay for medically necessary services at full charges.

2. Other Programs. Additional financial assistance programs are provided by the Hospital. These programs include payment alternatives and are described in the Hospital's other policies.

3. Specific Eligibility Guidelines. Patients must fulfill the following eligibility guidelines:

a. Family Income At or below Four Hundred (400%) percent (the "Clinic Test Amount Percentage") of the federal poverty income level.

Patients will be considered eligible for the clinic sliding scale discount program if (a) the patient's family income level does not exceed the Clinic Test Amount Percentage of the federal poverty income level and (b) the Hospital, having considered the patient's resources, has determined that the patient lacks the ability to pay all or some portion of the bill.

The Hospital will establish appropriate documentation requirements to verify eligibility.

Generally, the patient can apply for consideration under the clinic sliding scale program at any time.

Subject to a change in the patient's financial circumstances, eligibility will be granted for one year, unless otherwise determined by the Hospital, at which time the patient may reapply for clinic sliding scale status.

For patients who qualify for the clinic sliding scale program and whose annual family income is at or below the Clinic Test Amount Percentage of the federal poverty income level, the patient's bill for services will reflect full charges and then be discounted to an amount reflecting such family income as indicated in the table attached as **Schedule 1** (the "Clinic Table"). This "cost to charge" percentage will be reviewed and set by the Hospital on an annual basis. The discounted amount will be considered free / charity care. The balance remains the patient's financial responsibility.

b. **Family Income Over the Clinic Test Amount Percentage of the federal poverty level.**

For patients whose annual family income is greater than the Clinic Test Amount Percentage of the federal poverty income level, the patient will not be eligible for the sliding scale discount program, but will be eligible to apply for Free Care Funds, and if denied will be billed for services at gross charges, minus any applicable discount, and the charges billed will remain the patient's financial responsibility.

D. Sliding Scale Catastrophic Protection Policy

If the applicant, the applicant's spouse, and the applicant's dependents have an aggregate current balance of all accounts, including accounts in bad debt status, regardless of the age of any of the accounts, that exceeds 10% of annual household income, and depending on the value of the family's assets, the account balances will be reduced to the hospital's cost. (The discount can be higher if the Free Bed Funds Committee decides that the patient qualifies financially for a higher discount.)

E. Free Care / Charity Care Determination.

As noted above, free care generally involves cooperative efforts among the Hospital and the patient and / or the patient's family or representatives pursuant to which free or reduced bills are established for the patient's services.

An account may qualify for Charity Care if the patient and spouse (or both parents, if the patient is a dependent) are unemployed AND do not own property. Screening for employment and property ownership is done at the end of the usual billing cycle but before the account is assigned to a collection agency. Currently, only accounts with a balance of $1,000 or greater are screened. Any account that qualifies for referral to an outside collection agency as a Bad Debt account, even if the patient and spouse are not employed and don't own property, is so referred. This account, as with any other Bad Debt account, is pursued for collection by the primary collection agency. The account may be referred from the primary collection agency to a secondary agency at the discretion of the primary agency. If the account is not collected in full by the agencies, the returned balance will be written off in its entirity upon its return to the Hospital as Charity Care.

E. Extended Payment Guidelines.

The Hospital has other programs that include alternative payment arrangements. See the Hospital's Alternative Payment Arrangement Policy.

F. Accounting for Charity Care and Free Care.

Only that portion of a patient account that meets the clinic sliding scale program criteria is recognized as free care. Free care and charity care amounts are a reduction in charges made by the Hospital because of the patient's inability to pay for services at charges.

Revised 03/01/12

Exhibit C3

Greenwich Hospital
Alternative Payment Arrangement Policy

I. PURPOSE:

The purpose of this policy is to establish a policy for providing alternative payment arrangements to qualified patients who are determined, under the Hospital's eligibility criteria, to lack the ability to pay for care under customary terms and conditions.

Greenwich Hospital (the "Hospital") is guided by a mission that includes the provision of high quality care to all patients, including those who cannot pay for all or part of the essential care they receive at the Hospital. The Hospital is committed to treating all patients with compassion, from the bedside to the billing office, and including through payment and collection efforts. Furthermore, the Hospital is committed to advocating for expanding access to health care coverage.

The Hospital will maintain financial aid policies that are consistent with its mission and values and take into account an individual's ability to pay for medically necessary health care services.

II. POLICY:

A. General Statement of Need – Free Care distinguished from Charity Care Defined.

Recognizing its charitable mission, it is the policy of the Hospital to provide a reasonable amount of its services to eligible patients that do not have the ability to pay for care at full charges.

Free care generally involves cooperative efforts among the Hospital and the patient and / or the patient's family pursuant to which free or reduced bills are established for the patient's services.

Charity care is applied to an account when the patient and spouse (or both parents, if the patient is a dependent) are unemployed AND do not own property. Screening for employment and property ownership is done at the end of the usual billing cycle but before the account would be assigned to a collection agency. Currently only accounts with a balance of $1,000 or greater are screened. Accounts under $1,000 are treated in the same manner if the patient applies for Free Care Funds.

B. Notice.

The Hospital will provide notice and information to patients about the availability of free care under the clinic sliding scale discounting program in a number of ways, including by describing and / or referencing this policy on the Hospital's one page summary description of free bed funds and other free or reduced care policies (also referred to as the "Notice of Availability of Funds" document).

The Hospital will provide notice and information in a manner that complies with the requirements of law and is designed to make information easily available and accessible to patients.

The Hospital may develop a more detailed policy and procedure specifically describing the manner in which notices and information will be provided.

C. Eligibility for Alternative Payment Arrangements:

1. Generally. Extended payment arrangements may be established with the patient whether or not they qualify for the clinic sliding scale payment discounting program or any other free care or charity care program. Eligibility is determined on a case by case basis and made based on medical or financial hardship.

2. Types of Arrangements. The arrangements may include extended payment terms with reduced or no interest charges.

3. Failure to Comply. If the patient does not honor the payment arrangement based on the eligibility guidelines, the patient account may be referred to a collection agency.

4. Other Programs. Additional financial assistance programs are provided by the Hospital. These programs include payments alternatives and are described in the Hospital's other policies.

5. Specific Requirements. The Hospital, at its discretion, may enter into an agreement for payment of a patient's bill through monthly payments not to exceed twenty-four (24) months. Under this plan, patients with account balances greater than One Hundred Dollars ($100) that are determined to be the patient's responsibility (after applicability of other programs has been determined) may satisfy their accounts through interest-free monthly payments.

6. Exceptions. Any exceptions to the extended payment policy requires pre-approval from the Senior Vice President of the Hospital and will be coordinated with the Hospital's management oversight committee.

Exhibit C4

Greenwich Hospital
Waiver of Co-Pays / Deductibles or
Spend Down Requirements Policy

I. PURPOSE:

The purpose of this policy is to establish a policy for providing waivers of co-pays, deductibles or spend down requirements to qualified patients who are determined, under the Hospital's eligibility criteria, to lack the ability to pay for co-pays, deductibles or otherwise satisfy spend down requirements under customary terms and conditions.

Greenwich Hospital (the "Hospital") is guided by a mission that includes the provision of high quality care to all patients, including those who cannot pay for all or part of the essential care they receive at the Hospital. The Hospital is committed to treating all patients with compassion, from the bedside to the billing office, and including through payment and collection efforts. Furthermore, the Hospital is committed to advocating for expanding access to health care coverage.

The Hospital will maintain financial aid policies that are consistent with its mission and values and take into account an individual's ability to pay for medically necessary health care services.

The availability of this policy is determined on a case-by-case basis and is made based on medical and financial hardship.

II. POLICY:

A. General Statement of Need – Free Care distinguished from Charity Care Defined.

Recognizing its charitable mission, it is the policy of the Hospital to provide a reasonable amount of its services to eligible patients that do not have the ability to pay for care at full charges.

Free care generally involves cooperative efforts among the Hospital and the patient and / or the patient's family pursuant to which free or reduced bills are established for the patient's services.

Charity care is applied to an account when the patient and spouse (or both parents, if the patient is a dependent) are unemployed AND do not own property. Screening for employment and property ownership is done at the end of the usual billing cycle but before the account would be assigned to a collection agency. Currently only accounts with a balance of $1,000 or greater are screened. Accounts under $1,000 are treated in the same manner if the patient applies for Free Bed Funds.

B. Notice.

The Hospital will provide notice and information to patients about the availability of free care such as that provided under this policy in a number of ways, including by describing and / or referencing this policy on the Hospital's one page summary description of free bed funds and other free or reduced care policies (also referred to as the "Notice of Availability of Funds" document).

The Hospital will provide notice and information in a manner that complies with the requirements of law and is designed to make information easily available and accessible to patients.

The Hospital may develop a more detailed policy and procedure specifically describing the manner in which notices and information will be provided.

C. Eligibility for Waiver of Co-Pays, Deductibles or Spend Down Requirements:

1. Generally. The availability of this policy is determined on a case-by-case basis and is made based on medical and financial hardship.

2. Other Programs. Additional financial assistance programs are provided by the Hospital.

Revised 03/17/08

Exhibit D

Greenwich Hospital
Credit, Collection and Bad Debt Policy
General Overview

I. PURPOSE:

The purpose of this policy is to establish a policy for credit, collection and bad debt procedures.

Greenwich Hospital (the "Hospital") is guided by a mission that includes the provision of high quality care to all patients, including those who cannot pay for all or part of the essential care they receive at the Hospital. The Hospital is committed to treating all patients with compassion, from the bedside to the billing office, and including through payment and collection efforts. Furthermore, the Hospital is committed to advocating for expanding access to health care coverage.

The Hospital will maintain financial aid policies that are consistent with its mission and values and take into account an individual's ability to pay for medically necessary health care services.

II. POLICY:

1. Distinguishing Accounts. GH will, as noted in GH's other applicable policies and procedures, identify, and distinguish between, the accounts of those patients who have the financial resources to pay for all or some portion of their Hospital bills and the accounts of those who do not.

2. Evaluation. The Hospital will evaluate all past-due accounts for appropriate disposition and follow-up, consistent with this policy, the Hospital's Administrative Policy for Credit and Collection, and applicable law.

3. Collection Agencies / Law Firms. The Hospital will maintain contractual relationships with one or more collection agencies for collection of past due accounts. Each such collection agency, or law firm contracted by the agency, must be required to comply with the Hospital's Administrative Policy for Credit and Collections and applicable law. The Hospital prohibits all contracted collection agencies from reporting information of any kind regarding referred patients and their accounts to credit reporting agencies.

4. Cessation of Collection Efforts. If, at any time, the Hospital, or a collection agency or law firm, receives information that a patient is or may be eligible for financial assistance under one of these Programs or under any governmental or other program, the Hospital, collection agency, or law firm shall, consistent with applicable law, cease collection efforts until the Hospital determines the patient's eligibility for assistance.

5. Past Due Accounts / Bad Debt Status. The Hospital will classify a past due account as bad debt in accordance with the Hospital's Administrative Policy for Credit and Collections and relevant financial accounting standards and law. In determining bad debt, the Hospital may use a variety of collection efforts, including subsequent billings, follow up letters, telephone calls, personal contacts and referral to a collection agency or law firm.

Revised 02/11/09

Exhibit D1

GREENWICH HOSPITAL

ADMINISTRATIVE POLICY
FOR CREDIT AND COLLECTIONS

I. Purpose

A goal of Greenwich Hospital ("GH" or the "Hospital") is to provide the highest quality of medical care to its patients at the lowest cost. In order to do so, an efficient and equitable system must be established that will maximize the collection of patient account receivable balances in order to provide the cash flow required to operate the institution effectively.

In accordance with the above, the following credit and collection policy is hereby established for the Hospital.

Detailed procedures may be included in a credit and collection manual as maintained by the Hospital.

II. Source of Payment

A. Patient.

The patient has the primary responsibility for the payment of the patient's account. Except in an emergency, all patients capable of doing so will be required to sign a payment guarantee prior to admission or receipt of inpatient service.

The patient portion of the hospital bill may be satisfied through payment via one or more of the following sources:

1. Cash,
2. money order,
3. personal check,
4. bank check,
5. travelers checks
6. credit cards acceptable to the hospital
7. Money Transfer
8. ATM Debit Cards

B. Third Party Coverage.

The Hospital will extend credit on third party benefits assigned to the Hospital upon proper validation of coverage. Principal third party payers recognized in the Hospital generally, subject to Hospital approval, include the following:

1. Blue Cross
2. Managed Care Payers
3. Medicare
4. Commercial Insurance Companies (upon assignment of benefit to Hospital)
5. Workers Compensation
6. Medicaid
7. Others

The Hospital will cooperate with all third party payers to the fullest extent as per applicable agreements in order to facilitate the collection of patient bills.

C. Elective Services: Payment of Hospital Charges For Elective Hospital Services Not Covered By Insurance

The Hospital will require, or request payment for the difference between the estimated patient bill and the total available insurance coverage or approved social assistance. This procedure will be applied after giving consideration to the amount of the "patient portion", employment history and other Hospital indebtedness. Consideration of these factors will result in the distinction between required and requested payments, which are defined as follows:

Required Payment.

Any non-emergency patient may be required to make a deposit or pay estimated charges prior to visit. Payment of past due accounts may be required prior to a new hospital service. This encompasses co-payments, co-insurance, and deductibles.

Requested Payment.

Patients will be informed of the estimated patient portion of the bill, and a request for a deposit or payment of charges will generally not affect the admission procedure. These payments include co-payments, co-insurance, and deductibles.

D. Free Care Funding.

The Hospital has various Hospital Free Care Funds to assist those patients that meet the specific criteria and are unable to pay for services rendered. Please refer to the Hospital's Free Care Policy for additional information.

E. Clinic Sliding Scale Discounting Program.

The Hospital offers a Clinic Sliding Scale Discounting Program for eligible patients that do not meet the criteria for Free Bed Funds, but meet criteria to receive Hospital services at cost. Please refer to the Hospital's Clinic Sliding Scale Discounting Program for additional information.

F. Alternative Payment Arrangements.

For patients who do not qualify for either Free Care Bed Funds or the Hospital's Clinic Sliding Scale Discounting Program, the Hospital provides financial assistance to patients through discounts and alternative payment plans. Please refer to the Hospital's Alternative Payment Arrangement Policy for additional information.

G. Patient Inquiries.

Patient inquiries related to the credit and collection policies of the hospital may be answered or addressed only by those individuals designated within patient financial and / or admitting services.

IV. Admission Procedures.

A. Pre-Admissions.

The Hospital will pre-admit patients whenever possible. The source(s) of funds for payment of a patient's account must generally be verified prior to admission (i.e. confirmation directly with insurance plan, employer, or by examination and photocopy of appropriate insurance data).

B. Elective Admissions.

Elective admission referrals must generally be received in the Admitting office no later than 12 (noon) the business day prior to the expected admission date. All elective admissions are subject to the payment of Hospital charges not covered by insurance.

C. Emergency Admissions.

The Hospital will admit all emergency cases without regard to the financial status of the patient. See the Hospital's other policies and procedures relating to Emergency Department Admissions and Medical Screening Examinations.

V Billing Policy and Procedures.

All patients/guarantors will generally receive one or more statements including, when there is any third party coverage with respect to the patient's bill. See the Hospital's other policies and procedures relating to billing including but not limited to the Hospital's policies and procedures regarding the Hospital Billing Practices Act (P.A. 03-266).

VII Collection Policies and Procedures

Subject to the other applicable Hospital policies and procedures, these credit and collection policies and procedures generally apply to all self-pay accounts and / or the self-pay portion of patient accounts.

Accordingly, these collection policies and procedures generally apply to all pending Welfare, non-contractual insurance and self-pay (pure self-pay and residual self-pay) accounts. All rejected third party accounts will also be classified as self-pay until such time as further insurance is verified. Final bills are generally processed after discharge and are referred to the collection section of the Hospital.

VIII Analysis of accounts prior to collection turnover.

Prior to the turnover of any account into the outside collection process (collection agency or collection attorney), the Finance Department and / or a "Turnover Expeditor" (where available), will generally review a list of accounts.

The Expeditor will verify the following:

a) All third party insurance opportunities have been pursued and / or exhausted; this will include a review of previous patient accounts for third party insurance coverage, including Medicaid coverage.
b) Employment history and / or status.
c) Liquid asset values if they can be obtained.
d) No free care application is currently in process.

Account Balances Under $1,000. Based on the account review, and if the account value is under $1,000, the account may be referred to the collection agency. If, however, the patient applies for Free Care Funds, and the patient and spouse are not employed and don't own property, accounts with balances under $1,000 may be written off to Charity Care.

Account Balances Greater than or Equal to $1,000. If the account is $1000 or more, and it is determined under the Hospital's eligibility criteria that the patient and spouse are not employed and do not own property, the entire account balance may be written off to Charity Care. The account may be referred to an outside collection agency if the Expeditor believes that the patient has the financial ability to pay as determined under the Hospital's eligibility criteria.

In all cases, the cycle detailed for all accounts in this procedure will be interrupted by the following occurrences:

a. Receipt and verification of third party coverage,

b. Payment arrangements are agreed to and followed by the patient / guarantor,

c. Evidence that the accounts, or other legal consideration may result in an expedited referral to an agency or attorney, or

d. If at any time the patient indicates potential eligibility or interest in initiating an application for free care or sliding scale discount services. Patient will be referred to a free care coordinator or other patient financial services representative to receive a Free Care Application in this situation.

The above guidelines are reflected in the chart attached as **Exhibit Z.**

IX Bad Debt.

1. General Statement of Need.

Bad Debts are amounts considered to be uncollectible for which no likelihood of recovery at anytime in the future is expected. Bad debts are differentiated from charity care, which is defined as the inability to pay versus bad debt as the unwillingness of the patient to pay.

2. Patient Responsibility.

The patient is deemed responsible for the payment of provided services. Patient's responsibility also refers to all non-covered third party charges, such as insurance deductibles and copayments.

3. Uncollectible Debt.

If after reasonable and customary attempts to collect a bill, the debt remains unpaid, the debt may be deemed as uncollectible. The Hospital's collection efforts may include the use of a collection agency or attorney in addition to subsequent billings, follow up letters, telephone calls, and personal contact.

4. Account for Bad Debt.

Amounts determined as bad debt are recorded as expense net of recoveries and classified accordingly on the Hospital's Financial Statements.

X. Policies Governing Collection Agencies and Collection Attorneys

1. **Free care eligibility.**

   If at any time in the collection process the collection agency, or a collection attorney, becomes aware of a potential eligibility for free care, the collection is stopped and the account is referred back to the Hospital for pursuit of free care or other financial assistance programs. Collection agencies and collection attorneys will include Summary Notice of Free Care Availability in all communications with debtors.

2. **Prior approval.**

   Collection agencies and attorneys are instructed that pre-approval from the Hospital is required prior to the initiation of any legal action concerning a referred account. All requests will be reviewed by designated Credit & Collection staff then referred to the Senior V.P., Finance, or his/her designee for final approval.

3. **Property Liens.**

   Collection agencies and attorneys are instructed to severely limit the placement of property liens unless they can demonstrate significant financial assets by the debtor beyond the assets in the property. Pre-approvals will not be granted unless the account balance is over $1000 and the property(s) to be made subject to a lien are at least $200,000 in assessed value. Even if the account meets these criteria, a property lien may not be approved if in the view of the Hospital, the placement of the lien will cause financial hardship on the debtor.

4. Wage Garnishments.

Pre-approvals will be granted for wage garnishments if the following criteria are met and a written letter has been provided to the patient reiterating the following:

- The debtor has had an opportunity to apply for free care and has either refused or been found ineligible for free care assistance.
- The debtor does not fall under the definition of "uninsured" as set by the State of Connecticut.
- The debtor has not applied or qualified for sliding scale discounts to assist in the payment of their debt, or has qualified and has not paid.
- The debtor has not elected to make voluntary payments towards their debt.
- The placement of a wage garnishment is being approved as a last course of legal remedy.

Wage garnishments, if approved, will only apply to account balances over $500. Additionally, any State Marshall fee for administering the wage garnishment will be absorbed by the Hospital as a cost of collection. No interest will accrue on wage garnishments.

Any wage garnishments for employees of Yale New Haven Health, Yale-New Haven Hospital, Bridgeport Hospital, or Greenwich Hospital, or their affiliates, will require special review and attempts will be made through Human Resources to develop an alternative payment arrangement.

5. **Bank Executions.**

All bank executions, in addition to pre-approval, require special review by the Hospital for verification that the execution will not cause undue financial hardship on the debtor. If this cannot be determined, no bank execution will be ordered.

6. **Foreclosures and Writs of Capias.**

The Hospital will not pursue and will not initiate a writ of capias. The Hospital may ask for examinations of debtors but the Hospital itself will specifically indicate that the Hospital does not request any writ of capias. Except in unusual circumstances (e.g. where there is evidence of an ability to pay, multiple homes or properties, or the existence of significant assets), the Hospital will not pursue foreclosures for property liens.

7. Interest and Court Costs.

Interest will be allowed to accrue on accounts after legal court judgment is received. Interest will accrue at the current statutory rate. The Hospital will not allow interest to accrue greater than 50% of the account balance. If the principal is paid in full, the Hospital will waive payment of interest. Court costs will be assumed by the Hospital as a cost of collections and not charged to the debtor.

8. Collection Agency and Collection Attorney Reporting.

Monthly performance reports will be prepared by each collection agency and sent to the Hospital each month. Quarterly discussions will be held with each agency to discuss collection activities, pending legal proceedings, and problematic collection accounts. Performance reports will include the following information:

- Number and value of accounts in current inventory.
- Number and value of accounts received monthly from GH.
- Number and value of accounts returned as uncollectible from law firm.
- Recoveries, net of costs and fees
- Court costs and fees due from GH.
- Number of property liens approved and placed.
- Number of wage executions approved and placed.
- Number of bank executions approved and placed.

9. Reporting to Credit Reporting Agencies.

The Hospital prohibits all contracted collection agencies from reporting any information regarding referred patients or their accounts to credit reporting agencies.

XI. Administrative Write-offs

Due to the availability of specialized and tertiary / other level services at the Hospital, requests will be made from time to time by Hospital medical staff members and/or outside special interest groups for the Hospital to care for an adult or child from the United States or from a foreign country who require these services. When these cases are identified, the following criteria and other applicable factors will be considered in the decision to provide care with no consideration as to full payment:

- The clinical need of the patient, to include his/her prognosis.
- The adequacy of follow up care available in the patient's home country or city.
- The degree to which the Hospital's resources are especially suited for the care of the patient.
- The estimated costs of care.
- The availability of other specific funding to offset total costs of care.
- The willingness of physicians on the Hospital's medical staff to waive all or a portion of their professional and technical fees to support such patients.
- The total amount of free or discounted care provided by the Hospital to such patients during the fiscal year in which the request is made.

Requests must be made to the Senior Vice President, who will coordinate a review of the case based on the above mentioned criteria and who will utilize the management oversight committee for direction and / or input and exceptions to the Financial Assistance Programs.

XII. Free Care Funds Committee

1. Purpose

Financial Assistance Programs for Hospital Services will be overseen by a management oversight committee ("Committee") to review the case of any patient who may demonstrate a compelling hardship or personal circumstance which warrants financial assistance. The Committee will also review financial assistance requests from patients who are insured, but may demonstrate financial hardship causing difficulty in paying co-payments or deductibles.

2. Composition of Committee

The Committee is chaired by a Senior Vice President for the Hospital. Additional committee members may include Patient Financial Services Representatives, Patient Relations Representatives, finance and medical staff liaisons as needed. The committee will meet on a monthly basis, or more frequently if necessary.

3. Operating Protocols

- Patient accounts are referred to the Committee by patient financial services or patient relations representatives, or could be initiated by an appeal by the patient where free care services have been denied.

- Patients' accounts reviewed by the Committee typically do not meet the eligibility requirements for the provision of Charity Care.

- Typical Committee requests may include:

  - Insured patients with co-payments and deductibles where medical/financial hardship creates difficulty to pay patient's responsibility.

  - Self-pay patients with income/assets placing them above 250% of the poverty level, but where the patient's bill is significant and presents a financial hardship.

  - Medicare and Commercial insured patients that have exhausted insurance benefits or maximum coverage amounts.

  - Medicaid enrollees with a Medicaid spend down and demonstrated financial hardship.

- Committee will typically deny financial assistance requests for the following situations:

  - Lack of medical necessity for a service requested by a patient.

  - Cosmetic surgery

  - Financial hardship caused by the intentional failure of a patient to not follow through with a) medical advice, or b) health plan requirements such a payment of premium, notification of admission, or other requirements outlined in the patient's Subscriber Certificate.

The Committee will maintain minutes of meetings and will communicate findings to the appropriate departments as well as written communications to the affected patient.

IX Non-Emergency Significant Treatment of Patients Ineligible for Health Insurance.

This policy convenes a multi-disciplinary group of hospital staff to review patients who require significant services and who have very limited financial resources or community resources. For elective services, the review should be done as far in advance of the services as possible. For patients already receiving services, the review will be done in as timely a manner as possible and will help plan the patient's discharge and future hospital care.

X General Policies

Accounts identified as referrals to agencies or attorneys, and accounts directly written off will be reviewed and approved by the Patient Financial Services staff, Director of Patient Accounts, and / or the Senior Vice President, Finance.

XI Review of Administrative Policy for Credit and Collections.

The Administrative Policies for Credit and Collection will be reviewed on a semi-annual basis along with affected detailed operational policies involved in credit and collection. This review will examine existing policies in light of the current economic market, comparison to other peer hospital institutions for best practices, and with respect to annual financial budgets.