THE CHARLOTTE HUNGERFORD HOSPITAL
POLICY MANUAL

ADMINISTRATION	POLICY NO: 100.F5
	DATE OF ORIGIN: 3/20/00
	DATE REVISED: 08/13/03
SUBJECT: FINANCIAL ASSISTANCE	PAGE 1 OF 1

POLICY

It is the policy of The Charlotte Hungerford Hospital to grant free care funding to those patients who are determined in need of such funds.

PROCEDURE

1. Information is received via various methods, i.e., phone calls, letters, etc. that patient/guarantor is unable to meet their financial self-pay obligations.

2. A financial application is mailed to the guarantor utilizing the letter "FIN APP" which is printed directly from one of the patient's accounts. The financial application can be printed from a MOX cabinet entitled "Financial Application" which can be accessed by all users. A self-addressed envelope to the attention of the Patient Assistance Secretary is also forwarded.

3. Any accounts which have been forwarded to a collection agency cannot be considered for assistance.

4. Accounts will NOT be placed on hold until the completed application has been received.

5. If an application is received which is deemed incomplete, the required areas will be highlighted and mailed back to the guarantor and will follow normal collection activity.

6. Once an application is received and deemed complete, it will be prepared for evaluation and determination at the next Patient Assistance Committee. The Guarantor will be notified by the Secretary of the Committee's decision.

APPROVED BY: Hospital Policy & Procedure Steering Committee

ORIGINATING DEPARTMENT: Finance

From: Candace M. Carlson Taken by: Carlson,Candace M.
Subj: Re: PATIENT ASSIST P&P/04/09
Date: Mon May 18, 2009 12:53 pm

can you put this in our librarry?
%%%
Mon May 18, 2009 11:58 am   From: Joyce D. McKenna

THE CHARLOTTE HUNGERFORD HOSPITAL
POLICY MANUAL

FINANCE	POLICY NO: 14.P1
	DATE OF ORIGIN: 5/6/03
	DATE REVISED: 10/01/2008
	DATE REVIEWED:
SUBJECT: Patient Assistance Committee	PAGE 1 OF 4

PURPOSE

The purpose of the Patient Assistance Committee is to review, on a monthly basis, applications for financial assistance and grant where appropriate the use of free care bed funds or Charity Care to those patients who are determined to be in need of financial assistance. The Committe also will oversee and approve/deny applications for Senate Bill Adjustment recognition. Concern over a hospital bill should never prevent any individual from receiving health services.

PROCEDURE

1. The Charlotte Hungerford Hospital accepts all requests for financial assistance and will processes them according to the guidelines set forth by the Patient Assistance Committee (PAC). Requests can be made by phone or in writing directly from the patient/responsible party, or a financial counselor can refer a patient if they deem it appropriate after speaking to the patient/responsible party.

    a. Patients that were insured at the time of service and their account has been placed with a collection agency, will not be considered for financial assistance.

2. Financial screening application will be mailed or given out by financial advocate,per patient's request. Once returned, if more information is needed, a more detailed financial application will be sent to the patient.

3. The patient will be advised that normal collection routine will continue until the committee has reviewed and determined the outcome of their application for assistance.

4. Financial applications must be completed in their entirety, and all requested attachments must be present in order for the committee to properly review the application.

    a. In regards to the application, the following terms and definitions apply:

        i. "Family Income" - family income is defined as the total income that

is available to the household; this is to include combined salaries/income of husband and wife, as well as adults engaging in co-habitation where dependent child/children are present.

1. Income is determined utilizing the following formula:
   a. YTD/#WKS = GROSS WEEKLY
   b. GROSS WEEKLY x 52 = GROSS YEARLY
   c. GROSS YEARLY x .08 = NET YEARLY

2. PAC uses the Gross Yearly Income to determine discounts applicable to Senate Bill 568 and the Hill Burton guidelines and Net Monthly Income to determine payment arrangements and unspecified additional discounts.

3. Patients with liquid assets over $10,000 will not be eligbile for additional discounts unless approved at the discretion of the PA. Liquid assets are considered to be savings, checking, IRA's, CD's, etc.

ii. "Dependents" - the PAC follows the definition of dependent as set forth by the IRS.

iii. "Uninsured Patients" - PAC follows the defintion set forth by the State of Ct to determine "Uninsured" patients with the following clarifications: patients on a Medicaid "spendown" are also considered "Uninsured". Patients are not deemed uninsured until they have received a determination notice from DSS and were uninsured on the date of service.

iv. Based on the financial assistance application and a review of the family's annual income, discounts against services will be provided as follows:

* Care will be provided free for those uninsured patients who qualify as uninsured and verification has determined that their annual income is less than 200% of the Federal Income Poverty Level (FPL).

* Care will be provided at Hospital cost, as established by the Office of Health Care Access (OHCA), for those uninsured patients who request assistance and verification has determined that their annual income is between 200% and 250% of the FPL.

* Care will be discounted by 30% for those uninsured patients who request assistance and verification has determined that their annual income is between 250% and 400% of the FPL.

v. The Hospital will also consider the total medical expenses faced by a family and the family's ability to pay for those expenses, and

will consider offering greater assistance when possible to those families facing catastrophic medical expenses.

5. Patients who are deemed Uninsured and qualify for a reduction under Senate Bill 568 will have their accounts adjusted in accordance with Senate Bill 568 by the PAC secretary or designee.

6. The PAC secretary or designee will screen all applications against the Hill Burton Guidelines utilizing family income levels (as defined above). Patients will be provided a discount based upon these guidelines if applicable. This discount is given independently of the cost reduction adjustment, and one is not exclusive of the other.

7. Any applicant that is eligible for a 100% adjustment/discount will first be screened against free bed fund criteria. If qualified, case must be presented to PAC Committee for review and determination for the use of free bed funds. If not qualified, the case will NOT be presented to the PAC committee for review but will be reviewed by the supervisor of the Financial Counseling function and filed with all other cases.

8. Applications that are not processed at 100% will be presented to PAC for review and determination.

9. The completed packets will be assimilated by the secretary of the PAC committee or by the financial counselor who worked on the application. Whoever presents the packet at the meeting will not be eligible to participate in the vote.

10. In lieu of a completed application filled out by the patient, financial counselors can present cases on patient's behalf under the following circumstances:

a. The Patient has completed three or more Medicaid applications the CHH Staff but has been denied each time for failure to provide documentation to DSS

b. The patient is homeless and unreachable for follow up.

c. The patient is non-citizen and unreachable for follow up.

d. Contacting the patient for follow up could put them at risk.

In each of these cases the financial counselor or social worker must deem it impossible for the patient to follow up on their own behalf, and appropriate documentation must be provided to the committee attesting to such (Medicaid aps, Transunion reports,etc.) If the committee agrees that the patient has demonstrated need for assistance and is not able to go through the appropriate steps on their own,discounts can be given based on the case presented by the Financial Counselor. These discounts will be given at the committee's discretion.

11. Before patients are sent to Bad Debt, PAC reserves the right to run them

through Transunion to screen for possible Charity Care. Patients who return a Tranunion score which indicates indigence will be considered for a charity care adjustment. These patients will be exempt from the above process.

a. In addition to above, patients that have Medicare primary,and Medicaid secondary,and Medicare denies payment, these will be charity care,with an automatic adjustment put on the account using ACHARITY1. This rule will also apply if the patient has a commercial plan,and a Medicaid spenddown. If a patient is on a Medicaid spenddown,the bill will be faxed to DSS, senate bill adjustment applied, and the amount adjusted to ACHARITY1.

12. The Committee reviews and will approve, deny, or table any applications.

    a. Further discounts may be granted or denied based upon available funds and/or at the discretion of the committee based upon the facts presented for each individual case.

13. After Committee resolution, the secretary of the Committee will apply any further discounts where applicable, and mail appropriate notification letters to all applicants notifying them of the Committee's determination.

14. Any accounts that are not approved at 100% will automatically be set up on a monthly payment plan for the balance based on the hospitals policy and a contract will be mailed along with the notification letter. In special cases, as determined by the PAC, contractual arrangements can be set up that deviate from standard practice.

ORIGINATING DEPARTMENT: Financial Services

Revised: 07/22/2008

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THE CHARLOTTE HUNGERFORD HOSPITAL
APPLICATION FOR FREE BED FUND ASSISTANCE

INCOME/EXPENSES WORKSHEET [attach additional pages if needed]

1. NAME _____ PHONE#: _____
   ADDRESS: _____

2. INCOME: NUMBER OF MEMBERS IN HOUSEHOLD: _____ AGES _____
   TOTAL MONTHLY INCOME NET: _____
   SOURCE: _____ IF UNEMPLOYMENT - WHY? _____

3. EXPENSES - NECESSITIES:

	$/MONTH OR ANNUALLY	BALANCE DUE
RENT/MORTGAGE		
INSURANCE/TAXES-MORTGAGE		
FOOD		
MEDICAL		
PHARMACY		
DOCTORS _____		
_____		
CAR PAYMENTS		
CAR REPAIRS & GAS		
CAR INSURANCE AND TAXES		
CHILD CARE		
TELEPHONE		
ELECTRIC		
GAS OR ENERGY (OIL)		
WATER		
EXPENSES - COMFORT ITEMS:		
CABLE		
CELL PHONE		
DEBTS: CREDIT CARDS:		
OTHER EXPENSES - LIST WHAT		
_____		
TOTAL EXPENSES:		
TOTAL MONTHLY NET INCOME		
LESS-TOTAL MONTHLY EXPENSES		
REMAINING INCOME		

FINANCIAL DOCUMENTS REQUIRED [if applicable]

____ Federal Tax Return and W-2 Years: _____ _____

Income Verification - Examples included, but are not limited to:

_____Last 2 pay stubs for patient and/or spouse
_____Social Security check verification
_____Disability check verification
_____Copy of Certificate of Deposits Held
_____Copy of IRA, Mutual Fund or 401k
_____Interest earned from stocks and bonds
_____Recent Savings Account Statement
_____Recent Checking Account Statement
_____Copy of pension check
_____Alimony check copy
_____Child support check copy

___ Attach any information from Department of Social Services re: Approval, Spenddown, Denial

I HEREBY ACKNOWLEDGE THAT THE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND THAT ANY MISREPRESENTATIONS OF INFORMATION WILL RESULT IN REPAYMENT OF ANY FINANCIAL ASSISTANCE GRANTED. IN CONJUNCTION WITH THIS APPLICATION THE HOSPITAL MAY VERIFY THE ABOVE INFORMATION THROUGH THE USE OF A CREDIT BUREAU.

SIGNATURE: _____ DATE: _____

CHH SLIDING SCALE

Family Size	2012 Federal Poverty Level	200% Income From	200% Income Through	200% Charity Care	250% Income From	250% Income Through	250% Charity Care	400% Income From	400% Income Through	400% Charity Care
1	$11,170	$0	$22,340	100%	$22,341	$27,925	43.72%	$27,926	$44,680	30%
2	$15,130	$0	$30,260	100%	$30,261	$37,825	43.72%	$37,826	$60,520	30%
3	$19,090	$0	$38,180	100%	$38,181	$47,725	43.72%	$47,726	$76,360	30%
4	$23,050	$0	$46,100	100%	$46,101	$57,625	43.72%	$57,626	$92,200	30%
5	$27,010	$0	$54,020	100%	$54,021	$67,525	43.72%	$67,526	$108,040	30%
6	$30,970	$0	$61,940	100%	$61,941	$77,425	43.72%	$77,426	$123,880	30%
7	$34,930	$0	$69,860	100%	$69,861	$87,325	43.72%	$87,326	$139,720	30%
8	$38,890	$0	$77,780	100%	$77,781	$97,225	43.72%	$97,226	$155,560	30%
For each additional person, add:			$7,920			$9,900			$15,840	
9			$85,700	100%		$107,125	46.68%		$171,400	30%
10			$93,620	100%		$117,025	46.68%		$187,240	30%

Senate Bill Adjustment

Fiscal Year Start October 2012

46.68%

Start new adjustment December 1, 2012

THE CHARLOTTE HUNGERFORD HOSPITAL
ADMINISTRATIVE POLICY MANUAL

FINANCE /REGISTRATION	POLICY NO: 14.P1A
	DATE OF ORIGIN: 01/10/2013
	DATE REVISED:
SUBJECT: Pre-Emptive (Eligibility) Charity Care AdjustmenT	DATE REVIEWED:
	PAGE 1 OF 1

PURPOSE

To provide accessible care to our self pay patients in a fair, consistent, cost effective manner and to alleviate the financial burden of our self pay population.

PROCEDURE

1. At the point of registration, self pay patients (SP) will be screened for eligibility to receive the "Senate Bill Adjustment" that reduces self pay charges to cost. If the patient meets the income guidelines, the adjustment will be deemed charity care.

2. If a patient is at or below 250% of the Federal Poverty Guidelines and does not have liquid assets exceeding $10,000, they are considered eligible. The registrar will collect the income and family size in Meditech, and the patient will be entered as "SP". This financial screen will be valid for one billing month. The patient will be re-screened at their first visit of each month. The Cost adjustment as defined by OHCA will be added at the time of Final Bill and will be considered charity care.

   a. If Medicaid is removed from the account at time of registration due to ineligibility, the patient will be registered as "SP" only if they have already filled out their redetermination application.

   b. If a patient is on a Medicaid "spend down" they will be registered as "SP" as they have already been screened by the Department of Social Services.

3. If the patient does not qualify based on the income guidelines stated above, the registrar will enter the patient as "SPNC" into Meditech, and the patient will receive a 20% self pay discount. This is a self pay allowance.

4. If a patient does not want, or is not able, to divulge their financial information they will be registered as "SPNC". This does not preclude or prevent the patient from following up at a later date with a financial advocate.

5. If a patient does not have the information at time of registration, they will be registered as "SPNC" and Queued for a financial advocate to follow up.

6. This policy works in conjunction with Policy No 14.P1, Patient Assistance Committee.

APPROVED BY: Hospital Policy & Procedure Steering Committee

CROSS REFERENCE: Hospital Policy 14.P1, Patient Assistance Committee

ORIGINATING ENTITY: Financial Services

POLICY MANUAL

FINANCE	POLICY NO:	14.C3
	DATE OF ORIGIN:	10/1/03
	DATE REVISED:	10/1/04
SUBJECT: Cost Reduction Screenings	PAGE 1 OF 2	

PURPOSE

In accordance with Senate Bill 568 all patients, after completing the screening process, who meet the definition of "uninsured" as defined in SB 568 will have their account reduced to cost based on a percentage supplied by the State of Connecticut Office of Health Care Access.

PROCEDURE

1. Patients will enter the screening process through the Financial Counselors in the Emergency Area, the Financial Counselor in Finance, other departments, or self pay collection referral.

2. A determination will be made by the Hospital after a series of questions are answered by the patient as to whether they are likely to meet the "uninsured" criteria. (see Attachment 1) If patients are definitely over income, even through verbal verification, the patient may be set up on a contract. The "STATEMENT" insurance must be added and the account documented that the patient was verbally screened.

3. The screening application will be hand given or mailed to the patient for completion. The application consists of two portions:

    1. The upper portion to be completed and appropriate income verified if the patient is requesting only to be screened for the cost reduction

    2. The second half will be used to determine if a patient can be considered for free bed funding or sliding scale discounts if further information is completed and provided.

4. Once a patient has notified the Financial Counselor that they wish to be considered for cost reduction and/or free bed assistance, the statement date set for T+21 which will allow the patient 21 days to complete and return the necessary paperwork. A MOX message must also be sent to American Adjustment Bureau to stop further collection activity.

5. No follow up to this process is completed if patient does not complete and return the application. Normal collection activity will follow. However, based on SB 568, if a patient requests to be screened at a later date, the patient must be given another application.

6. Financial applications will be processed by the Financial Counselors. Only those patients who wish to be considered for additional assistance

need to have their case documented and provided to the Patient Assistance Committee for review at its normal monthly meeting based on the criteria in Policy 14P.1.

7. For accounts where a cost reduction only applies, the Financial Counselor in Finance is responsible for adding the ASB568 adjustment to the account. A copy of the case record will be sent to the Team Leader, Finance for audit purposes. Balances will be combined, insurance STATEMENT added and account will be automatically set up on a monthly payment plan which meets Hospital guidelines.

8. A letter will be sent to the patient advising them of the amount of their cost reduction, along with a copy of the monthly payment contract.

APPROVED BY: _____ DATE: _____
Vice President, Finance & Treasurer

Originating Entity: Financial Services

Cross Reference: Finance Policy 14.P1

Attachment A
ARE YOU UNINSURED?

If you meet the definition of "uninsured" as defined by Section 19a-673 of the Connecticut General Statutes, you may be eligible to have your balance(s) reduced. You are considered uninsured if you meet **ALL** of the following:

You have one or more outstanding balances due to The Charlotte Hungerford Hospital.

You have applied and been denied eligibility for any medical or health care coverage provided under Medicaid or State Administered General Assistance ("SAGA") due to failure to satisfy income or other eligibility requirements. (Proof of denial is required.)

You are not eligible for coverage for hospital services under any other health or accident insurance program (including workers' compensation, third-party liability, motor vehicle insurance).

Your household income is at or below 250% of the Federal Poverty Income Guidelines. (Proof of income is required.)

The Hospital shall use the poverty guidelines and charge to cost ratio that is effect on the date that the patient applies for assistance for all accounts.

THE CHARLOTTE HUNGERFORD HOSPITAL

POLICY MANUAL

FINANCIAL SERVICES	POLICY NO:	14.C1
	DATE OF ORIGIN:	4/24/95
	DATE REVISED:	6/15/2010
SUBJECT: Referral to Collection Agencies	PAGE 1 OF 1	

POLICY

To ensure a standardized process for collection referrals for all accounts where Charlotte Hungerford Hospital has determined that the amount due is a patient balance and is uncollectable from any other source other than the guarantor of the account.

PROCEDURE

1. If an account fits into the below criteria, then it is considered eligible for bad debt and may be referred to a collection agency.
   a. The balance on the account is a patient balance (determined by remittance or patient has been deemed a self pay patient with no insurance coverage).
      i. If patient is deemed self-pay, patient enters the screening process for cost reduction as indicated by Connecticut state law (Senate Bill 568) and Hospital policy 14.C3.
      ii. Balances due from a self pay patient are those that are remaining after the above screening/process is completed and all other methods of payment are exhausted.
   b. The patient has received a minimum of two Hospital statements, then a two letter pre-collection series or has had knowledge of the debt for a minimum of 90 days.
   c. The address on the account has been determined to be undeliverable by the US Postal Service and a minimum of 90 days has passed since the date of service.

2. Collection agency referrals will be completed on a monthly basis.
   a. Eight reports are run to pull accounts eligible for BD flagging: BD AAB, BD MED, NLE AAB, NLE AAB1, NLE MED, NLE MED1, BDPSAAB and BDSPMED.

3. If the account is flagged for bad debt, the Transfer To/From Bad Debt routine is used to assign the accounts to the appropriate agency.
   a. American gets accounts that have the last name A-M
   b. Medcon gets accounts that have the last name N-Z

4. At the beginning of each month, assigned accounts are downloaded into a file and that file is pulled electronically by the applicable Collection Agency.

5. Each Monday, a report of payments and adjustments for each agency is run and faxed to them for their records.

APPROVED BY: _____ DATE: _____

Originating Entity: Financial Services

THE CHARLOTTE HUNGERFORD HOSPITAL

POLICY MANUAL

FINANCE	POLICY NO:	14.B7
	DATE OF ORIGIN:	5/13/05
	DATE REVISED:	6/15/2010
SUBJECT: Bankruptcies	PAGE 1 of 1	

POLICY

To ensure a standardized process for handling bankruptcy notices.

PROCEDURE

1. Bankruptcy notices will be handled by the Self Pay Collector.

2. Notices are received via the U.S. Mail.

3. Upon receipt of the notice review the patient account(s) involved by entering the Social Security Number(s) listed on the notice. Review both utilizing the MEDITECH search features G#(SS#) and SS# to identify all accounts affected by the bankruptcy. All family members under the age of 18 at the time of service are included in the bankruptcy adjustment.

4. Notate the affected accounts with BANKNOT and date of the notice. Place all statements on hold and add NVS to CCI Status. Send copy of notice to AAB and/or Medconn Collection Agencies.

5. When a notice of Discharge is received adjust off any patient balances up to the file or order date using the adjustment code BANKDIS notating in the comment of adjustment the date of order. On accounts up to the file date that are not yet patient balance, place the statement on hold. Cashiering will adjust these to zero at the time of insurance posting through the normal review process. Copy of notice to AAB and/or Medconn.

6. When a notice of Denial is received document accounts with BANKDEN & date of notice. Remove statement hold & continue to bill as normal. Copy of notice to AAB and/or Medconn.

8. If any Bad Debt (BD) accounts are affected, adjust patient balance and copy notice and forward to the appropriate agency.

APPROVED BY: _____ DATE: _____

Vice President, Finance & Treasurer

Originating Entity: Financial Services