**SUBJECT: YALE NEW HAVEN HEALTH
YALE NEW HAVEN HOSPITAL AND BRIDGEPORT HOSPITAL
CREDIT AND COLLECTION POLICY**

I. Purpose

The primary responsibility of Yale New Haven Health is to provide the highest quality of medical care to its patients at the lowest cost. In order to meet these requirements, 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 Yale New Haven Health. Detailed procedures and exceptions to this policy will be included in a credit and collection manual as developed by the Director of Patient Accounts and the Credit and Collection Manager.

II. Definitions

In this credit policy, the term "patient" includes the party responsible for the payment of the hospital bill. Further, the expression, "patient portion" is taken to include all non-covered third party charges, such as insurance deductibles, copays, co-insurance, etc.

Inpatient

A patient admitted to the hospital and provided room, board and continues nursing service.

Clinic Patient

A patient who is registered in the hospital's outpatient clinic registration system and treated in one or more of the specialty clinics.

Private Referred Patient

A patient referred to one or more of the hospital's ancillary service areas by either Bridgeport Hospital, Yale University, or other private physicians.

Observation (Applies to Bridgeport Hospital only)
A patient provided care outside of the Emergency Department who requires more than the brief encounter. This avoids a full hospital admission.

III. Source of Payment

A. Patient

The primary responsibility of settlement of the account will rest with the patient. All patients, capable of doing so, will be required to sign a payment guarantee prior to admission or receipt of Inpatient service. In an controversy, default, or misrepresentation the hospital will contact the patient for payment of the bill.

B. Third Party Coverage

Yale New Haven Health will extend credit on third party benefits assigned to the hospital upon proper validation of coverage. Principal third party payers recognized in the hospital system are as follows:

Blue Cross
Managed Care carriers
Medicare
Tricare
Commercial Insurance Companies
(upon assignment of benefits to Hospital)
Workers Compensation
Medicaid

Yale-New Haven Health System will cooperate with all third party payers to the fullest extent in order to facilitate the collection of patient bills.

C. Patient Balance (Self-pay accounts and/or residual balances after Third party payments)

The patient portion of the hospital bill is to be satisfied thru payment via one or more of the following sources:

1. Cash, money orders, personal, bank, or travelers checks
2. Credit cards acceptable to the hospital
3. Savings accounts, income tax refunds
4. Sale of investments, conversion of insurance policies
5. Loans from banks, credit unions, finance companies, etc.
6. Money Transfer
7. **ATM Debit Cards**

D. Payment of Uninsured Hospital Charges

Yale-New Haven Health System 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 will be required to make a deposit or pay estimated charges prior to visit. All past due accounts would also be required to be paid prior to the current admission. **This encompasses co-payments, co-insurance, deductibles and deposits.**

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 not affect the admission procedure. These payments include co-payments, co-insurance, deductibles and deposits.

E. Free Care Funding

Yale-New Haven Health System recognizes its responsibility to those patients that meet the specific criteria and are unable to pay for services rendered. Various Hospital Free Bed Funds are available to meet this recognized need. **The Patient Account Advocate will perform a financial screen on all self-pay patients for the purpose of potential financial assistance with any unpaid balances**

F. Patient Inquires

Patient inquiries related to the credit and collection policies of the hospital must be addressed by only those individuals designated within Patient Financial & Admitting Services.

IV. Admission Procedures

A. Pre-Admissions

Yale-New Haven Health System will pre-admit patients whenever possible. The payment sources chosen for settlement of a patient's account must be verified prior to admission - (i.e. confirmation directly with insurance plan, employer, or by examination and photocopy of appropriate insurance data). In addition, the provisions of Section III - D must be satisfied.

B. Elective Admissions

Elective admission referrals must be received in the Admitting office for:
Bridgeport Hospital - within 48 hours prior to the admission.
Yale New Have Hospital - no later than 12 (noon) the business day prior to the expected admission date.

All elective admissions are subject to the payment of uninsured Hospital charges as established in Section III - D.

C. Emergency Admissions

Yale-New Haven Health System will admit all emergency cases irrespective of the financial condition of the patient. All admission of an emergency nature will be handled and controlled through the Admitting office.

The admitting physician must certify as to the emergency status when requesting the admission. **If the Admitting/Registration needs assistance, this will be handled by the Chairman of the Respective Department.** Emergency patients are required to make arrangements to pay the difference between the final projected patient bill and the total estimated insurance coverage by time of discharge.

V. Installment Contracts

The Hospital, at its discretion, may enter into an agreement for settlement of a patient's bill thru monthly installment payments not to exceed ten months. Under this plan, an advance deposit of 10% of beginning balances per month for ten months. In addition, the finance charges will not be imposed. Payments will not be less than $65 per month. We also entertain settlement offers of no less than 80% of the balance. Payment must be a lump sum within 10 days.

Patients who are financially unable to settle bills under the ten months arrangements must make alternate arrangements for repayment within a twenty-four months repayment period with the collection manager's approval. **This policy applies to all departments in the hospital.**

VI. Billing Policy and Procedures

All patients/guarantors will receive a series of statements, when there is any third party coverage, and/or bills when there is no third party coverage or all third party coverage has been satisfied (paid or rejected) as follows:

1. All patients/guarantors, with non-participating/ non-contracted insurance will be sent a statement sixty days after original UB regardless of third party status.
2. Ninety days after original UB has been sent the account will automatically reject and begin billing the patient.
3. Each statement/bill will contain a message for each third party payment plan based on the non-contracted carriers. Non-contracted carrier will incorporate a message directed to the patient/guarantor requesting assistance with their insurance company however, leave the patient/guarantor ultimately liable for the bill.
4. Patient/guarantor will be dunned for an Amount Due after all parties have been billed for a period of 90 days.

VII. Collection Policies and Procedures

These collection policies and procedures 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. **These patients are asked to make a required patient payment in advance or at the time of service. (See attachment A for "Collection Scripts").**
Final bills are processed one day after discharge (ten days in the event of a computer detected audit error) ***pg. 6 #1** and are referred to the collection section of the Patient & Admitting Services department. Specific policies and procedures vary with the classification of the account as follows:

A. Pending Welfare

1. During hospitalization, Agency Coordinators will attempt to explain the welfare application procedure, aid the patient in completing the application and assist the patient in the preparation for the district office visit.
2. If possible, prior to discharge, the patient will be seen to review the status of the application. Appropriate financial information and documentation should be maintained.
3. There will be continued communication with the patient, after discharge, from the Agency Coordinator until approval or denial of the state application is obtained.

B. Non-contractual (commercial) insurance

Follow-up on these cases will be as follows:

Days after original UB	Procedure
60	Statement with commercial insurance "assumed rejection" message
90	First bill - patient responsibility this will begin Self Pay after Rejection statements **(see Section VIII, D)**

C. Self-Pay

1. After discharge, the account will be referred to the Collection section of the SBO. Whenever possible, appropriate financial information and documentation should be in SDK.
2. The Collection Department s will "audit" the account for information contained on system.

3. The account will then be processed through the appropriate system of bills with messages, letters and phone calls as follows:

Days after Discharge	Procedure
1 - 5	Cycle 1 bill
15	First call to patient
30	Cycle 2 bill
60	Cycle 3 bill
90 days	Cycle 4 bill
120 or sooner	Turn over to agency or attorney

D. Self-Pay - Residual

Residual balances after third party payment/rejected will proceed through the appropriate system of bills with messages. Based on the volume, phone calls will be made on accounts over $1000.00 for Yale New Haven Hospital, and over $600.00 for Bridgeport Hospital.

Days after Third Party Satisfied	Procedures
1 - 5	First bill with message
15 - 30	First phone contact
30	Second bill with message
60	Third bill with message
90	Fourth bill with message
120 or sooner	Turnover to Agency or attorney

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

1. Receipt and verification of third party coverage
2. Payment arrangements are agreed to and followed by the patient/guarantor
3. Evidence that the account is uncollectible, a history of bad debt accounts, or other legal consideration may result in an expedited referral to an agency or attorney.

D. Patients with the following payor sources and/or receiving the following services are NOT asked to pay a required patient payment at time of visit:

A. "Emergency" cases
B. Pending, emergency, managed Medicaid
C. Medicare
D. Workers Compensation

VIII. General Policies

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

1. Whenever possible, arrangements with local banks for loans to the patient should be secured to relieve the Hospital from the collection process.
2. Minor balances, under $9.99, should be automatically written off 30 days after discharge if no response is received from the patient.
3. Accounts identified as referrals to agencies or attorneys, and accounts directly written off will be reviewed and approved by he Director of Patient Accounts, VP-SBO and the Senior Vice President-Finance.

Proponent: Financial
8/1/80
Rev 9/11/00;7/12/01

SCRIPT ATTACHMENT A

APPROPRIATE RESPONSES TO PAYMENT OBJECTIONS	
OBJECTIONS	**RESPONSES**
"I have never had to pay at time of service before."	"I understand your concern, but changes in our office procedure were needed to contend with rising costs in health care. Paying at time of service helps us reduce administrative costs. Would you like to pay with...."
"My insurance will pay."	"We verified your insurance coverage and their representative noted a deductible/co-pay that is your responsibility. Would you like to pay by cash, check, or charge?"
"I saw the doctor for five minutes. Why is the bill so high?"	"The office visit is based on the quality of care and counsel, not the amount of time spent with the doctor. Our physicians are among the best in the area, which is reflected in our pricing structure."
"My doctor told me not to worry about a bill."	"Your physician didn't mean you wouldn't have to pay, but that you shouldn't worry about the bill because your medical problem is your first priority."
"Just send me a bill."	"We can no longer delay collecting payments."
"I did not bring any money or anything to pay with."	"We can bill you for this initial visit, but your follow-up visits will require payment at time of service."
"You seemed more concerned about my bill than my care."	"I assure you that we are concerned about your care first. Payment for that care ensures that we can continue to provide the quality treatment you and other patients expect."
"My ex-spouse pays for all the bills."	"I understand there may be an agreement between you are your former husband/wife, but that is something you will need to take up with them. I can give you a receipt to send to your former spouse showing it has been paid so that you can be reimbursed. So, how would you like to pay?"

COLLECTION SCRIPTS
"ATTACHMENT A"

POOR TECHNIQUES	BETTER TECHNIQUES
Do you want to pay?	The fee for your service is....
We expect payment.....	We ask our patients.....
The office requires.....	Our office procedure is.....
The charge/cost is.....	Do you prefer to pay by cash, check or credit card?

SUBJECT: FREE BED FUND SPENDING POLICY

POLICY:

I. Applicable Endowment Funds

A. The spending policy will apply to non-nominator bed funds.

B. The spending policy will apply to nominator bed funds with the approval of the outside nominator and/or the determination that the spending rate is consistent with the donor's original intent.

II. Spending Policy for Applicable Funds

The spending policy for year one will be 5% of the average market value for the fund for the preceding three years. In the second year and all subsequent years, the spending policy will be based on a weighted average of the prior year spending, adjusted for inflation (70%) and the amount that would have been spent using 5% of the current market value of the endowment fund (30%).

III. Preservation of Funds

Inflation Adjusted Corpus

Prior to June 30th of each fiscal year, the inflation-adjusted corpus will be updated by taking the prior fiscal year's Consumer Price Index (CPI) and adjusting the previous year's prior fiscal year's inflation adjusted corpus by this factor.

The previous year's prior fiscal year's inflation adjusted corpus is defined as the original gift multiplied by the accumulated CPI since the date of the gift to the end of the prior fiscal year for nominator bed funds.

Fund Balance

The market value of the endowment funds will be monitored closely to the inflation-adjusted corpus to be sure that the original purchasing power of the endowment is preserved. The Finance Committee will evaluate how much of the fund, if any, should be spent.

IV. Other Than Temporary Impairment of Investments

Evaluations will automatically incorporate any and all changes in endowment balances including any realized and unrealized losses including other than temporary impairment of investment adjusted required by FASB 125.

V. Evaluations of Asset Allocation Targets

Asset allocation targets will be evaluated at least annually to ensure sufficient liquidity to meet annual spending budgets.

Proponent: Financial
Issued: 3/05

Administrative Approval: _____
President and Chief Executive Officer

SUBJECT: POLICY FOR FREE CARE FUNDS

PURPOSE:

To establish a policy for the use of funds that have been donated to Bridgeport Hospital ("BH" or the "Hospital") and other funds that have been designated by BH to provide free care. The Hospital also has other policies related to charity care.

POLICY:

A. General Statement of Need

The Hospital has received charitable contributions to endowments that are restricted by the donors to use to provide free care to patients (hereinafter referred to as "Free Bed Funds"). Some of the donated funds contain additional restrictions (home address of patient, church, nominator, etc.); other funds have no additional restrictions. The Hospital has established a spending policy on the distribution of these Free Bed Funds. In addition, BH provides additional free care to patients from Hospital operating funds.

B. Notice

The Hospital will provide notice and information to patients about Free Care Funds in a number of ways, including: publishing notices in newspapers of general circulation; posting notices in appropriate locations throughout the Hospital; ensuring the availability of a one-page summary description of Free Bed Funds and how to apply for them; providing individual written notice to patients; making available written information in other forms that may be helpful to patients; and, holding open houses.

The Hospital will provide notice and information in a manner that complies with the requirements of law, including the Connecticut law concerning hospital bed funds that 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. Free Care Criteria

The Hospital will provide free care to all uninsured patients who have filed for City or State assistance; provide formal documentation showing a legitimate denial; and, provide proof that their income level does not exceed two and a half times (250%) the poverty level. The Hospital will, in appropriate circumstances, determine that the patient does not have liquid assets that can be used to pay all or some portion of the bill without financial hardship or distress. The hospital will establish appropriate documentation requirements to verify eligibility.

D. Eligibility for Donated Free Bed Funds with No Specified Nominator

The Hospital has Free Bed Funds where the historical dollar value is restricted and the net appreciation and income are available to support free beds for patients unable to pay, but no specific nominator is named. The allocation of the availability of these funds is based on the Hospital's Spending Policy.

These Free Bed Funds will be available only to patients meeting the above" Free Care Criteria" after all possibilities of third party reimbursement have been exhausted.

In addition, the Hospital, at its discretion and on a case by case basis, may provide Free Bed 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 Bed 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 Bed 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. It may also choose to provide Free Bed Funds for only a portion of the request, if, in its judgment, awarding Free Bed 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).

E. Eligibility for Donated Free Bed Funds with Geographic or Other Additional Restrictions But No Specified Nominator

Patients must fulfill the above eligibility guidelines for "Free Care Criteria" and reside in the specific geographic location dictated by the original gift, or meet the other additional eligibility restrictions contained in the original gift.

F. Eligibility for Hospital Operating Funds

Once Free Bed Funds with no nominator or other special restriction are exhausted up to the annual endowment spending policy limit, and if there are patients who meet the "Free Care Criteria", BH will provide additional free care to patients from operating funds.

BH will also make available additional free care funds from operations for other types of requests where the patient demonstrates a compelling hardship or personal circumstance which warrants providing financial assistance. These requests will be identified and recommended for free care funds by a committee comprised by Management.

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

The Hospital has Free Bed 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 is based on the Hospital's spending policy.

The Hospital will notify nominators semi-annually of the status of Free Bed Funds for which they have a nomination role. The nominator may request the use of Free Bed Funds for any eligible patient who meets the guidelines for a given fund. Each nominator will receive an annual report of Free Bed Funds utilized by patient (subject to privacy restrictions). Nominators may request to rollover unused funds to the subsequent year for their purposes or designate remaining funds to be used by BH for general free care purposes. In addition, BH may award funds in cases in which the donor provided that the Hospital has the power to award the funds if the nominator did not.

H. Accounting of Free Funds

For donated Free Bed Funds with no specified nominator and donated Free Bed Funds with geographic or other additional restrictions but no specified nominator:

The Free Bed Funds available for the fiscal year will be based on the Hospital's Spending Policy, and will be applied to the patient requests up to 90 days after the close of the fiscal year. During this 90-day period, accounts will be identified and recommended for Free Bed Funds by a committee comprised by Management. The funds will be relieved at cost.

For BH Operating Funds:

For patients whose income level does not exceed two and a half times (250%) the poverty level and deemed eligible for the use of free funds, BH operating funds will be available, subsequent to the exhaustion of the Free Bed Funds available according to the Hospital Spending Policy for "donated Free Bed Funds, with no specified nominator." The funds will be relieved at cost.

For donated Free Bed Funds restricted to use by an outside nominator:

The Free Bed Funds available for the fiscal year will be based on the Hospital Spending Policy, and will be applied to the nominator requests up to 90 days after the close of the fiscal year. If the total amount available to be spent in a year is not applied based on nominator request, the remaining amounts can be carried forward and made available for use in the following year or may, depending on the nominator's wishes and/or the terms of the original gift, be awarded by the Hospital to eligible patients. Funds utilized for patients who meet the financial criteria for other Free Bed Funds will be relieved at cost.

Proponent: Financial
Issued: 3/05

TITLE: FINANCIAL ASSISTANCE/CHARITY CARE POLICY: SLIDING SCALE DISCOUNTING PROGRAM

I. PURPOSE:

To establish a policy for providing financial assistance under a sliding scale discounting program to uninsured patients who are determined, under the hospital's eligibility criteria, to lack the ability to pay for care at full charges.

Bridgeport Hospital (the "Hospital") is guided by a mission to provide 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, including 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 that take into account an individual's ability to pay for medically necessary health care services.

In addition to charity care provided under this sliding scale discounting program established by the Hospital, free care is provided to uninsured and insured patients in accordance with the Hospital's Policy for Free Care Funds. The free care is provided to patients eligible for it and is funded by free bed funds given to the Hospital as well as by Hospital operating funds. Further, the Hospital provides relief and assistance to insured patients by waiving or reducing co-payments and/or deductibles and Medicaid spend-down requirements on a case-by-case basis determined on grounds of medical and financial hardship.

POLICY:

A. General Statement of Need

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.

Charity care is defined as care provided to a patient who is determined under the Hospital's eligibility criteria to lack the ability to pay. The Hospital will establish appropriate documentation requirements to verify financial status.

B. Notice

The Hospital will provide notice and information to patients about the availability of charity care under the sliding scale discounting program in a number of ways, including describing this policy on the one-page summary description of free bed funds and other free or reduced care policies.

The Hospital will provide notice and information in a manner that complies with requirements of law that 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 Sliding Scale Program

The Hospital provides care through the sliding scale discounting programs to uninsured patients that do not have the ability to pay for medically necessary services at full charges. The sliding scale discounting program is designed to assist uninsured patients eligible for the sliding scale who are not otherwise eligible or do not comply with the application process for assistance under the Hospital's Policy for Free Care Funds.

Additional financial assistance programs are provided by the Hospital for patients who do not qualify for the sliding scale program or free care under the Hospital's Policy for Free Care Funds. These programs include prompt pay discounts and extended payment terms with no interest. In addition, the Hospital provides relief to patients not eligible for free care or the sliding scale program on a case-by-case basis.

Patients must fulfill the following eligibility guidelines:

At or below 350 percent of the federal poverty level:

Patients will be considered eligible for the sliding scale discount program if their income level does not exceed 350 percent of the federal poverty level, and the Hospital, having considered the patient's resources, has determined that they lack the ability to pay all or some portion of the bill. The Hospital will establish appropriate documentation requirements to verify eligibility.

Generally, the patient must apply for consideration under the sliding scale program within 30 days of determining self-pay or uninsured status. Eligibility will be granted for one (1) year, unless otherwise determined by the Hospital, at which time the patient may reapply for sliding scale status. For patients that qualify for the sliding scale program, and whose annual family income is at or below 350 percent of the federal poverty level, the patient's bill for services will reflect full charges and then be discounted to a percentage that approximates cost. This cost-to-charge percentage will be reviewed and set on an annual basis. This discount will be considered free/ charity care. The balance will be the patient's financial responsibility.

Over 350 percent of the federal poverty level:

For patients whose annual family income is greater than 350 percent of the federal poverty level, the patient will not be eligible for the sliding scale discount program, and, unless provided relief under a case-by-case review, will be billed for services at gross charges; the charges billed will be the patient's financial responsibility.

D. Charity Care Determination

Charity care is defined as care provided to a patient who is determined under the Hospital's eligibility criteria to lack the ability to pay. Free care is a component of charity care based on established eligibility criteria that awards free care to qualified individuals. The Hospital's determination of charity care for eligible patients may occur at any time during the patient's admission, dates of

service, discharge or collection process. The collection process may further allow the Hospital to determine whether patients qualify for sliding scale programs or ultimately are designated as charity care based on inability to pay.

E. Payment Guidelines

Extended payment arrangements may be established with the patient, whether they qualify for sliding scale payment or they are ineligible. If the patient does not honor the payment arrangement based on the eligibility guideline, the amount is referred to a collection agency at the discounted rate.

F. Accounting for Charity and Free Care

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

Proponent: Financial
Issued: 3/05

Administrative Approval: _____
President and Chief Executive Officer

SUBJECT: FREE CARE AND HOSPITAL BED FUNDS

I. PURPOSE:

To establish a policy to identify patients eligible for free care, including patients eligible for use of specific funds donated to Bridgeport Hospital to provide free care ("Hospital Bed Funds").

II. GENERAL STATEMENT OF NEED:

The Hospital has received charitable contributions from donors specifically requesting that earnings on funds be made available to provide free care to patients. Some of these funds contain restrictions on use such as children only, geographic residence of patient, type of illness, membership in a particular church or other organization, or designation by a specific person. Other funds have no restrictions on use. Due to the variety of restrictions placed on the use of contributions, the Hospital has established the following policy on free care and on the application of income from certain Hospital Bed Funds. This policy applies to Hospital Bed Funds for which Bridgeport Hospital has the right to designate the use of the funds as well as to Hospital Bed Funds for which there is no one so designated. Where other persons or institutions have the right to designate the use of Hospital Bed Funds, (a "nominator") they may choose to follow this policy.

III. PROCEDURE:

A. Notice

Published Notice: Each fiscal year the Hospital will publish in a newspaper of general circulation in its area notice of the availability of Hospital Bed Funds.

Posted Notice: The Hospital also will post a notice of the availability of Hospital Bed Funds in both English and Spanish and in a conspicuous public place in its registration areas (with a forty-eight (48) to seventy-two (72) point type size), including the Registration Department, Emergency Department, Social Services Department and Patient Financial Services Office. This notice will include generalized information about the Hospital Bed Funds, including Bridgeport Hospital's program to administer the Hospital Bed Funds and will refer a patient to Patient Financial Services Office personnel for further information or an application.

Individual Written Notice: The Hospital will include in a patient's admitting package a one-page statement notifying patients of the availability of Hospital Bed Funds and how to apply for them. The admitting package is made generally available to the public. The one-page statement shall distinguish Hospital Bed Funds from other sources of financial assistance and shall be available in the Registration Department, Emergency Department, Social Services Department and Patient Financial Services Office. The Hospital will have a booklet describing specific Hospital Bed Funds available in the admitting area and other ambulatory registration sites. If during the admissions process or during its review of the financial resources of the patient, the hospital reasonably believes the patient will have limited funds to pay for any portion of the hospitalization not covered by insurance, the Hospital shall provide the summary to each such patient.

B. General Eligibility Requirements for Free Care for Hospital Bed Funds for which Bridgeport Hospital is Nominator or Where There Is No Specific Nominator

1. Patients who are unable to pay for their Hospital expenses may apply for free care at Bridgeport Hospital upon admission to the Hospital, during their hospitalization, upon discharge or when arranging payment. The patient will be required to complete an Application For Free Care available in the Registration or Patient Financial Services Office. During the application review, the patient's account will be placed on hold and all collection activity will cease until the Hospital determines whether the patient qualifies for free care. Patients also may be referred to complete an Application For Free Care by Social Services Department, Clinical Departments or Administration.

2. The Patient Financial Services Office will review each Application for Free Care using the following guidelines:

a) Free care will be available to patients only after all possibilities of direct payment or third party reimbursement have been exhausted. Patients also must have applied for General and Medicaid assistance, and provide formal documentation showing legitimate denial or the Hospital must be able to determine that such patients are not insured or eligible for General or Medicaid assistance.

b) Generally, patients will be considered eligible for free care provided that the patient's family income level does not exceed two and one half times the poverty level. However, individual patient circumstances may vary and the Hospital may consider other factors in determining if a patient is eligible for free care.

c) If a patient requests to be considered for hospital bed funds to cover all or a part of the patient's Hospital bill, the Patient Financial Services Office will review the application and accept an application if it meets the criteria and deny an application which does not. If the Patient Financial Services Office believes an exception to the eligibility criteria should be made, a written recommendation from the Patient Financial Services Office will be made to the Hospital's Free Care Committee which will approve or deny such requests. The patient will be notified in writing of the decision of the Patient Financial Services Office or, if applicable, the Free Care Committee and, if the patient's application is rejected, the reasons for the rejection. A copy of the decision shall be kept with the Application for Free Care in the Patient Financial Services Office. Patients whose applications are denied for a particular Hospital admission may apply for hospital bed funds for subsequent treatment or admissions at Bridgeport Hospital.

3. The Free Care Committee shall consist of the Director of Patient Financial and Registration Services, a representative from the Pastoral Care Department, a representative from the Social Service Department and such other persons as may be appointed from time to time by the President of Bridgeport Hospital.

C. Eligibility for Hospital Bed Funds with No Specified Nominator

Patients must fulfill the General Eligibility Requirements specified in IIIB.

D. Eligibility for Hospital Bed Funds with Geographic Restrictions but no Specified Nominator

Patients must fulfill the General Eligibility Requirements specified in IIIB and reside in the specific geographic location dictated by the original gift.

E. Eligibility for Hospital Bed Funds Restricted to use designated by an Outside Nominator

The Hospital will notify nominators annually of the status of Hospital Bed Funds for which they have a nomination role. The nominator may request the use of the Hospital Bed Fund for any patient who meets the guidelines of such Fund as dictated by the original gift. The Hospital will request the nominator's adherence to the General Eligibility Requirements specified in IIIB. Use of such Hospital Bed Fund shall be considered free care and reported as such by the Hospital.

During the year, the Hospital may identify to a nominator the names of patients who may qualify for the nominator's Hospital Bed Fund and seek approval from the nominator for use of its Hospital Bed Fund by such patients.

F. Accounting of Hospital Bed Funds

1. Earnings on the Hospital Bed Funds during the October 1 through September 30 fiscal year, less the reasonable costs of administering the Hospital Bed Funds, will be applied to patient or nominator requests made within 30 days after the close of the fiscal year for care rendered during such fiscal year. The Hospital shall apply such funds to such patients' accounts within 60 days after the close of the fiscal year.

2. An accounting shall be prepared as of the end of each fiscal year for each Hospital Bed Fund identifying:

(i) the number of applications for use of the Hospital Bed Fund;

(ii) the use of the Hospital Bed Fund including patient name, Hospital account number, and amount of the Hospital Bed Fund applied to a patient's account;

(iii) the fair market value of the principal of the Hospital Bed Fund on September 30;

(iv) earnings of the Hospital Bed Fund during the fiscal year;

(v) earnings reinvested as principal of the Hospital Bed Fund, if any;

(vi) the income available for patient care that fiscal year, i.e., earnings less expenses.

3. If the Hospital Bed Fund is restricted to use by an outside nominator, a copy of such accounting will be provided to the nominator.

4. The accountings prepared pursuant to IIIF2 shall be permanently retained by the Hospital, and made available to the Office of Health Care Access upon request.

Reference: C.G.S. §19a-509b
Proponent: Hospital Counsel

10/91

Reviewed: 12/98
Revised: 1/93;10/93;2/96;1/99;3/99

Administrative Approval: _____
President and Chief Executive Officer

YALE-NEW HAVEN HOSPITAL

ADDENDUM TO
FINANCIAL ASSISTANCE POLICIES
March, 2006

1. Yale New Haven Health System hospitals will begin to employ in early 2006 a financial screening tool in conjunction with the major credit reporting agencies. Such screening tool will allow member hospitals to triage self-pay accounts as well as potential accounts with underinsurance for ability to pay. Threshold criteria will be established to triage accounts for further collection.

2. Policies will be modified to allow Yale-New Haven and Bridgeport Hospital to consider a patient's financial assets when determining an ability to pay. (Greenwich Hospital currently has the ability to review assets)

3. The current policies at Yale-New Haven and Bridgeport Hospitals require a Medicaid denial prior to approval for free care. We have been asked to review the wisdom of this policy in light of the high certainty of denials for undocumented residents. After careful review and discussion, we believe that this requirement should stand. There are many examples of coverage by Medicaid for services that were originally thought ineligible. We also do not want to set up special consideration for undocumented residents when we require documented residents to obtain a Medicaid denial. Greenwich Hospital currently does not require a Medicaid denial.

4. The sliding scale program should be made available to as many patients as possible. Currently, patients are required to submit proof of income prior to obtaining the sliding scale discount. We recommend that this process continue to be considered, but all patient denials for sliding scale should be reviewed by a manager prior to rejection to confirm that any and all attempts have been made to obtain the required information.

5. Currently, patients who present for non-emergency services and who have no ability to pay, are denied access to services without full or partial payment. In all cases, the physician is notified and asked to determine the emergent or non-emergent condition. Patients may complete a financial assistance application for coverage and when approved, are granted access to services. We propose that this policy be modified to restrict access to services only until a patient has completed our financial assistance application and provided proof of income. Patients who are ultimately denied financial assistance will be noted in the records and upon the patient's next visit, must comply with the non-emergent payment policy.

6. Patients who complete a financial assistance application, provide proof of income, but do not provide a Medicaid denial (50% of cases) will be screened for income eligibility. If the patient meets the income criteria, the account would be referred to Century, even if the patient is employed or owns property. No accounts will be referred to a collection attorney if income is below 400% of FPL.

7. Any patient may avail themselves of a payment plan for their portion of the hospital bill. Such payment plans shall be limited to balances of greater than $50. Greenwich Hospital currently uses and may continue to use a $10 threshold. Depending upon the balance due, payment plans may be established for up to 12 months interest free. Larger balance payment plans for an extended period may be established upon the approval of the Vice President, Corporate Business Services, or an SVP of the health system (including hospital CFOs). In 2006, the health system will establish credit arrangements with one or more health care credit card companies to assist patients with a periodic payment plan. This plan will be initially rolled out at Yale-New Haven and Bridgeport Hospitals.

8. Any care provided to patients that do not complete the appropriate financial assistance applications and are deemed to be unable to pay their health care bill will be classified as charity care. This includes international patients for whom the hospital agrees to provide services at no cost, either prospectively or retrospectively due to the patient's financial circumstances. These will no longer be classified as administrative allowances.

9. The policy will be modified to automatically write off small balances of under $50 after the full cycle of bills have been provided to a patient. The previous ceiling was $100. As a note, any balance of under $1000 is always referred to Century collections as only balances over $1000 are referred to collection attorneys. Greenwich Hospital currently has established a write off threshold of $10 and will continue to use this amount.

Classification: XXXX	ADMINISTRATIVE POLICY AND PROCEURE
Yale New Haven Health System:	**Yale-New Haven Hospital/ Bridgeport Hospital/ Greenwich Hospital**
Title: Billing and Collection	**Policy Number:**
Date Approved: 09-20-2013	**Approved by:** Board of Directors
Date Reviewed: n/a	**Date Revised: n/a**
Distribution: XXXX	Policy Type: I
Supersedes: YNHH Administrative Policy for Credit and Collections, Bridgeport Hospital Credit and Collection Policy (9-4), Greenwich Hospital Billing and Collection: Bad Debt Policy (A-J:2)	

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.

"*FAP*" means the Hospital's Financial Assistance Policy.

"*FAP-eligible individual*" means an individual eligible for financial assistance under the hospital's FAP, without regard to whether the individual has applied for assistance under the FAP.

"*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. As part of its collection process, the Hospital will make reasonable efforts to determine if an individual is eligible for financial assistance under its FAP. In the event of nonpayment, where based on information in its possession a person is not FAP-eligible individual, the Hospital (and any collection agency or other party to which it has referred debt) may engage in extraordinary collection actions as defined on Attachment I.

PROCEDURE:

A. General & Limitation on Billing

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 as defined herein; and (ii) eligibility for free bed funds; and

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

    c. If a patient is determined to be an uninsured patient as defined herein, the patient will be eligible for free care under the Hospital's FAP.

2. Following a determination of eligibility for financial assistance under the Hospital's FAP, the Hospital will charge all FAP-eligible individuals: (a) for emergency or other medically necessary care, the costs of such care (which the Hospital ensures is no more than amounts generally billed (AGB) to persons who have insurance covering emergency or other medically necessary care), and (b) no more than gross charges for all other care.

3. Each bill and all collection notice from the Hospital, or any collection agent acting on behalf of the Hospital, must include the YNHHS Summary of Financial Assistance Programs. In addition, at Greenwich Hospital the Availability of Hospital Funds notice must be disseminated in accordance with the Greenwich Hospital Bed Fund Agreement.

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. Reasonable efforts – Accounts Receivable ("A/R") Collections

The Hospital will follow its A/R billing cycle in accordance with internal operational processes and practices. As part of such processes and practices, the Hospital will, at a minimum, notify patients about its FAP from the date care is provided and throughout the A/R billing cycle (or during such period as is required by law, whichever is longer) by posting signs throughout the Hospital, distributing a plain language summary of its FAP in all billing statements, and discussing the FAP with eligible patients.

C. Outside Collections

1. The Hospital will seek to maintain written contractual relationships with one or more collection agents and attorneys 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 Accounts, the VP, Corporate Business Services 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, VP, Corporate Business Services, Director of Patient Accounts, and Manager,

Credit & Collections

REFERENCES:

Conn. Gen. Statutes §19a-673 and §19a-673(a) – (d)
Internal Revenue Code §501(r)(6)
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:

YNHHS Financial Assistance Programs

Attachment I

STANDARDS & SCOPE OF COLLECTION PRACTICES

1. Prior approval of extraordinary collection action and reasonable efforts to determine if FAP-eligible individual.

   The Hospital (and any collection agency or other party to which it has referred debt) shall not engage in any extraordinary collection action ("ECA") before making reasonable efforts to determine if a patient is an FAP-eligible individual, and further must obtain written approval from the Manager of Credit/Collections, prior to the initiation of any ECA, including as set forth below.

2. ECA Defined:

   (a) Commencement of a legal action concerning a referred account

   (b) 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 Financial Assistance 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 $125,000 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.

   (c) 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.

(d) 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.

(e) 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.

(f) 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.

(g) 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.

Classification: XXXX	ADMINISTRATIVE POLICIES & PROCEDURES
Yale New Haven Health System:	Yale-New Haven Hospital/ Bridgeport Hospital/ Greenwich Hospital
Title: Financial Assistance Programs	**Policy Number**:
Date Approved: 09-20-2013	**Approved by**: Boards of Trustees
Date Reviewed: n/a	**Date Revised**: 2-1-2014
Distribution: XXXX	**Policy Type**: I
Supersedes: Yale New Haven Hospital Financial Assistance Programs for Hospital Services (NC:F-4), Bridgeport Hospital Financial Assistance Programs for Hospital Services (9-13), Greenwich Hospital Overview of Financial Assistance Programs for Hospital Services	

PURPOSE

Yale New Haven Health System ("YNHHS") recognizes that patients may not be able to pay for medically necessary health care without financial assistance. Consistent with its mission, YNHHS is committed to assuring that the ability to pay will be considered carefully when setting amounts due for emergency and other medically necessary hospital services.

In recognition of its role to help those in need of financial assistance, YNHHS has established the Financial Assistance Programs ("FAP") to assist with emergency and other medically necessary care. The objectives of the FAP are to:

(i) Specify all financial assistance available under the FAP;
(ii) Provide clear information regarding eligibility criteria, application requirements and the method for applying for financial assistance under the FAP;
(iii) The basis for calculating amounts charged to patients for emergency or other medically necessary care; and
(iv) The YNHHS measures to widely publicize this FAP within the communities served by YNHHS.

POLICY

I. Scope of FAP

The FAP apply to emergency and medically necessary inpatient and outpatient services billed by Bridgeport Hospital, Greenwich Hospital, or Yale-New Haven Hospital (each, a "Hospital") to patients without insurance. The FAP exclude (a) routine waivers of deductibles, co-payments and coinsurance imposed by third party payers; (b) private room or private duty nurses; (c)

services that are not medically necessary, such as elective cosmetic surgery; (d) other elective convenience fees, such as television or telephone charges, and (e) other discounts or reductions in charges not expressly described in this Policy.

I. Eligibility for Financial Assistance

Individuals who are uninsured and who have applied, but do not qualify for, State medical assistance, may be eligible for financial assistance under YNHHS FAP as more specifically described in Section IV below. The award of financial assistance shall be based on an individual determination of financial need. In addition, YNHHS has Bed Funds available.

II. Amounts Billed to FAP-Eligible Patients

Federal law requires that amounts billed by a hospital to an approved FAP-eligible patient must be less than the amounts generally billed ("AGB") by that hospital for any emergency or medically necessary care it provides, and less than the gross charges for any medical care. Under this FAP, YNHHS bills FAP-eligible patients no more than the costs of care, and ensures that the cost of care billed to FAP-eligible patients is less than the AGB for each Hospital. YNHHS calculates AGB prospectively, based on current Medicare fee-for-service rates, including Medicare beneficiary cost-sharing amounts.

III. Notice/Access to FAP

Each Hospital provides notice and information to patients about its FAP in a number of ways, including publishing notices in newspapers of general circulation; posting notices and FAP applications on the Hospital website; posting notices throughout the Hospital and at all points of patient registration; ensuring the availability of a one-page summary description of FAP and applications at all points of registration, billing and collection; providing written notice of FAP in all billing statements; providing notice of FAP in all oral communications with patients regarding the amount due; and holding open houses and other informational sessions. Each Hospital will provide notice and information in a manner that complies with the requirements of all applicable laws, including IRC Section 501(r) and Connecticut law concerning hospital bed funds.

Patients may ask Patient Registration, Patient Financial Services and Social Work/Case Management about initiating the Application process. Information about applying for financial assistance is also available on YNHHS Hospitals' websites.

IV. Application and Eligibility Determinations

To be eligible for financial assistance, the patient must complete an application for financial assistance ("Application"). Each Hospital has its own Application that sets forth (i) its FAP available programs and eligibility requirements, (ii) the documentation requirements for determinations of eligibility, and (iii) the contact information for FAP assistance. The Application also specifies (i) that the Hospital will respond to each Application in writing, (ii) that patients may re-apply for FAP at any time, and (iii) that additional free bed funds become

available every year.

Hospitals must make reasonable efforts to determine eligibility and document any determinations of financial assistance eligibility in the applicable patient accounts. Hospitals may not deny financial assistance under the FAP based on failure to provide information or documents that the FAP or the Application do not require as part of the Application. Hospitals may not engage in any extraordinary collection action, as defined in Hospital's Billing and Collection Policy, before making reasonable efforts to determine if a patient is eligible for financial assistance, within any legally required time-frames.

Once Hospital identifies a patient is FAP-eligible, Hospital shall:

(i) Provide a billing statement indicating amount owed as FAP-eligible patient, including the AGB for care provided and the Hospital's calculation of amounts owed or instructions how to obtain such information;

(ii) Refund any excess payments made by patients on FAP eligible accounts, as required by law; and

(iii) Take reasonable measures to reverse any extraordinary collection actions.

V. Programs

YNHHS Hospitals offer the financial assistance programs described below to uninsured patients and each program must be managed by YNHHS Hospitals in accordance with this Policy. The eligibility criteria and specific documentation requirements for each program must appear in each Hospital's Summary of Financial Assistance Programs and Application. YNHHS Hospitals may have different eligibility criteria and application processes for the different financial assistance programs.

A. Free Care. The Free Care program provides care at no cost to YNHHS Hospital patients with gross annual family income less than 250% of the Federal Poverty Level, and who have applied for, and been denied, State medical assistance.

B. Restricted Bed Funds. Restricted Bed Funds are funds that have been donated to the Hospital to provide free or discounted care that are restricted to patients that meet certain eligibility criteria, such as certain town residency, church membership, or specific medical conditions. Information about these specific eligibility requirements is included on each YNHHS Hospital's Application.

C. Discounted Care. If a patient's gross annual family income is 251% or above the Federal Poverty Level, the Hospital will discount care to the lessor of (a) its cost of care, or (b) the Hospital's AGB.

VI. Management Oversight Committee

The FAP will be overseen by a management oversight committee chaired by a Senior Vice President, YNHHS and comprised of representatives from the System Business Office, patient financial services, patient relations, finance, and the medical staff, as necessary. This committee

will meet on a bi-monthly basis to discuss specific cases of patient financial hardship, collection matters, and the status of the FAP.

RELATED POLICIES

YNHHS Billing and Collections Policy (xx)
Yale-New Haven Hospital Policy – Distribution of Free Care Funds NC:F-2
Yale-New Haven Hospital Policy – Sliding Scale Discounting Program NC:F-5
Greenwich Hospital Policy for Free Care Funds
Greenwich Hospital Clinic Sliding Scale-Discounting Program
Greenwich Hospital Alternative Payment Arrangement Policy
Greenwich Hospital Waiver of Co-Pays/Deductibles or Spend Down Requirements Policy
Bridgeport Hospital Policy for Free Care Funds (9-14)
Bridgeport Hospital Sliding Scale Discounting Program (9-15)

REFERENCES

Internal Revenue Code 501(c)(3)
Internal Revenue Code 501(r)
Conn. Gen. Stat. § 19a-673 et seq.