WESTERN CONNECTICUT HEALTH NETWORK
DANBURY HOSPITAL • NEW MILFORD HOSPITAL

Patient Financial Services - *Financial Assistance Policy*

Effective Date: 5/1/1997

Revised Date: 7/15/14

I. POLICY

A. Western Connecticut Health Network is a not for profit, tax-exempt entity with a charitable mission of providing medically necessary health care services to residents of the City of Danbury and the Hospital's defined primary service area, regardless of their financial status and ability to pay.

B. It is the policy of Western Connecticut Health Network to provide "Financial Assistance" (either free care or reduced patient obligations) to persons or families where: (i) there is limited or no health insurance available; (ii) the patient fails to qualify for governmental assistance (for example Medicare or Medicaid); (iii) the patient cooperates with the Hospital in providing the requested information; (iv) the patient demonstrates financial need; and (v) Western Connecticut Health Network makes an administrative determination that Financial Assistance is appropriate.

C. After the Hospital determines that a patient is eligible for Financial Assistance, the Hospital will determine the amount of Financial Assistance available to the patient by utilizing the Charitable Assistance Guidelines (**Exhibit 1**), which are based upon the most recent Federal Poverty Guidelines issued by the U.S. Department of Health and Human Services ("FPGs").

D. In the case of patients who qualify for discounted (but not free) care, the Hospital will work in good faith with patients to establish payment plans that are fair and workable in light of each patient's available resources.

E. Western Connecticut Health Network will regularly review this Financial Assistance Policy to ensure that at all times it: (i) reflects the philosophy and mission of the Hospital; (ii) explains the decision processes of who may be eligible for Financial Assistance and in what amounts; and (iii) complies with all applicable state and federal laws, rules, and regulations concerning the provision of financial assistance to indigent patients. In the event that applicable laws, rules or regulations are changed, supplemented or clarified through interpretative guidance, the Hospital will modify this Policy and its practices accordingly.

II. PURPOSE

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A. Western Connecticut Health Network is committed to advancing the health and well-being of those in its community by providing an integrated high quality and cost effective network of health care services and education centered around a teaching hospital, consistent with current medical standards for the prevention, diagnosis, treatment, and rehabilitation of illness; and anticipating and responding to new developments in the health care system; and integrating its services with those of other medical and social service organizations in the region (e.g., home health care agencies, long term care facilities, and physical, mental, alcohol, and drug rehabilitation) so as to optimize the availability of such services within the region in a cost effective manner. Consistent with this mission, Western Connecticut Health Network recognizes its obligation to the community it serves to provide financial assistance to indigent persons within the community.

B. In furtherance of its charitable mission, Western Connecticut Health Network will provide both (i) emergency treatment to any person requiring such care; and (ii) essential, *non-emergent* care to patients who are permanent residents of its primary service area who meet the conditions and criteria set forth in this Policy, without regard to the patients' ability to pay for such care. Elective procedures generally will not be considered essential, non-emergent care and usually will not be eligible for Financial Assistance.

III. ELIGIBILITY AND DETERMINATION OF AMOUNT

A. Eligibility: A patient will be eligible for Financial Assistance if the patient: (i) has limited or no health insurance; (ii) applies for but is deemed ineligible for governmental assistance (for example Medicare, Medicaid or State-Administered General Assistance); (iii) cooperates with the Hospital in providing the requested information; and (iv) demonstrates "financial need" or is deceased with no estate, no payment source and no health insurance. In addition, a patient will be eligible for Financial Assistance in the event Western Connecticut Health Network administration, in its discretion, deems such eligibility appropriate under a patient's unique circumstances (for example, where a patient has insurance coverage but lacks the financial resources to pay applicable co-pays, deductibles and excess amounts). For purposes of this Policy, the term "patient" is used with regard to the patient or the applicable

payment source for the patient's care (*e.g.*, parent, guardian or other responsible party).

B. Financial Need: A patient may be deemed to have financial need: based on either **indigency/financial hardship** or **medical hardship** (each as defined below).

1. Indigency/Financial Hardship: A patient may demonstrate financial hardship by showing that the patient has **income** and **available assets** below the FPG thresholds set forth on **Exhibit 1** (as amended from time to time to reflect the most current FPGs published by DHHS). For these purposes, "income" includes salaries, legal judgments, unemployment compensation, dividends, interest checks and other recurrent sources of income or resources. "Available assets" includes savings, certificates of deposit, individual retirement accounts, marketable securities or similar liquid assets readily convertible to cash (however, in no event will this term include a patient's primary residence). *[Note: Consider whether to leave assets out of the eligibility determination, and factor into the analysis of an appropriate payment plan for the remaining balance owed.]*

   If a patient's income and available assets combined are at or below **600%** of the FPGs, the patient will receive some form of Financial Assistance. The Financial Assistance may be either a complete waiver of all patient responsibility or a discount or reduced patient obligation, depending on the patient's income.

   - If a patient's income and available assets combined fallbetween **0%** and**400%** of the FPGs, the patient will have no financial responsibility for the care provided by the Hospital. This means that the full charges for services rendered (including copayment and deductible amounts) are completely waived.

   - If a patient's income and available assets combined are greater than **400%** of the FPGs but not more than **500%** of the FPGs, the patient will qualify for a 50% discount on the charges for services rendered.

- If a patient's income and available assets combined are greater than **500%** of the FPGs but not more than **600%** of the FPGs, the patient will qualify for a 30% discount on the charges for services rendered.

2. Medical Hardship: In addition to income and assets, Western Connecticut Health Network will also consider Financial Assistance where a patient's medical bills are of such an amount that payment threatens the patient's financial survival. In such circumstances, the discount to be offered to the patient will be determined by Hospital personnel in their discretion.

C. Calculation of Amounts to Be Billed: The net amount to be billed to a patient qualifying for financial assistance hereunder will be determined by (i) calculating the gross charges for services rendered to the patient, and (ii) applying the appropriate discount (as determined pursuant to the above and Exhibit 1). Notwithstanding the foregoing, however:

1. Consistent with Connecticut law, any uninsured patient whose income (alone, without regard to available assets) falls below **250%** of the FPGs will not be charged more than Danbury Hospital's cost of providing services to the patient; and

2. Consistent with applicable Federal tax laws, the net amount billed to any patient qualifying for financial assistance pursuant to this Policy (after applying the appropriate financial assistance discount determined above) will not exceed the greater of (i) the net amount that would be charged based on applying an average of the Hospital's three highest commercial payor discounts, or (ii) Medicare rates.

[Note: The provisions of 501(r) are subject to multiple interpretations. The language proposed here is the more favorable interpretation for hospitals. Depending on how these issues evolve through the development of regulations and interpretative guidance, however, we may need to switch to the more patient-friendly approach, whereby the charge limitation is applied at the gross charge level, before the financial assistance discount is applied.]

IV. PROCEDURES AND OBLIGATIONS FOR DETERMINING ELIGIBIITY FOR FINANCIAL ASSISTANCE

A. All self-pay patients will be informed of the availability of financial assistance pursuant to this Policy.

B. Because a patient is not eligible under this Policy until s/he has applied for and been deemed ineligible for federal and state governmental assistance programs, Danbury Hospital's Financial Services Department will assist patients in enrolling in federal and state governmental assistance programs. Trained financial counselors and other personnel may be contacted at (203) 739-7773 or (203) 730-5800 for any assistance required in completing the Application for Financial Assistance or with any other materials required by the Hospital under this Policy.

C. Although ideally the Hospital will make a determination about Financial Assistance during pre-registration or prior to discharge, this may not be possible, either because the patient does not provide the necessary documentation, or the patient's circumstances change after discharge, or in other circumstances where a given patient's circumstances or needs are identified. **A patient may request consideration at any time, and Western Connecticut Health Network will evaluate a patient's eligibility under this Policy as requested, up to and including consideration during the collections and judgment phase.** Patients are encouraged to contact the Hospital if their circumstances change or if additional need is identified. The Hospital will review all information provided and relevant circumstances bearing on the need for Financial Assistance, will make a determination of eligibility, and will promptly notify the patient of his/her financial obligations, if any, as set forth below.

D. <u>Eligibility Determination Procedure</u>

1. Hospital staff will immediately forward to the Hospital's financial counselors a copy of the pre-admission record for any patient who has no insurance. Financial counselors will contact the patient to schedule a financial interview as soon as is practicable but ideally before admission for a non-emergent, medically necessary service, and prior to discharge for an emergency admission. For emergency services, the Hospital will

not delay screening or treatment of an emergency medical condition pending this financial interview.

2. To determine whether a patient is eligible for Financial Assistance, the patient will be required to complete the Patient Financial Worksheet (**Exhibit 2**). The Worksheet will be made readily available to patients through methods including (without limitation) posting on the Hospital's website, distribution at the Hospital's Patient Registration and Admissions areas and the Patient Financial Services offices, and inclusion in the informational binders provided in patient rooms.

3. Patients must return the Worksheet to the financial counselor in the self-addressed stamped envelope provided by the Hospital within ten (10) days. Failure to timely supply required information will result in denial of a patient's request for provision of Financial Assistance. Patients are obligated to cooperate and provide all information needed in a timely manner.The Hospital will make reasonable efforts to offer and provide assistance to patients in connection with the completion of the Worksheet. However, if assistance is needed in gathering necessary information or materials requested as part of the Financial Assistance qualifying process, patients are encouraged to contact one of the Hospital's trained financial counselors at (203) 739-7773 or (203) 730-5800. Financial counselors also are available to assist patients with assessing their financial situations, gathering information requested by the Hospital, and assisting with similar tasks.

4. As part of the financial interview process,financial counselors will request the following documentation in order to process and validate Financial Assistance applications:

   a. Confirmation of annual income and assets:

      - Last four pay stubs and/or W2 form, social security award, unemployment compensation letter
      - Most recent income tax return
      - Most recent checking and savings account statements for all accounts upon which patient is listed as an account-holder

- Banking/investment account statements

b. Confirmation of patient's Social Security Number and birth date. Proof must be in the form of one of the following:

- Social Security Card
- Birth certificate
- Baptismal Certificate
- Military Discharge Papers
- School Records
- Drivers License

c. Confirmation of residence in the form of one or more of the following:

- Mortgage Book
- Current Rent Receipt
- Current Lease
- Tax Bill
- Room and Board Statement
- Utility Bill
- Written Verification from Landlord

E. Although the information above is required from patients seeking Financial Assistance, the Hospital in its discretion may choose not to require some or all documentation depending upon circumstances and the patient's ability to obtain documentation.

F. Patients have an obligation to provide information reasonably requested by the Hospital so that the Hospital can make a determination of a patient's eligibility for Financial Assistance. **If a patient claims s/he has no means to pay but fails to provide the information reasonably requested by the Hospital, there will be no Financial Assistance extended and normal collection efforts may be pursued in the Hospital's sole discretion.**

G. Eligibility and Notification Process:

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1. Upon receipt of a patient's Patient Financial Worksheet, the Financial Services Department will review the patient's application to determine that it is complete, including all required documentation. If it is not complete, the application will be returned to the patient for completion. If the Hospital returns an application to a patient as incomplete, the Hospital will contact that patient by telephone. If the Hospital is able to reach the patient by telephone, the Hospital will offer the patient an in-person or telephonic interview to determine such patient's eligibility for Financial Assistance. If the Hospital is unable to reach the patient by telephone, or if there is no listed telephone number available, the Hospital will send a letter to the patient that details what is needed and that explains to the patient that it is his/her responsibility to contact the Hospital within ten (10) days of receiving the letter. The Hospital's trained financial counselors will offer to meet with the patient to assist him/her in completing the application so that the Hospital has all of the necessary information to make a determination on the patient's eligibility for Financial Assistance.

2. The Financial Services Department will complete the Financial Assistance Eligibility Determination Form attached as **Exhibit 3**, and will determine the amount the patient owes, if any. The Financial Services Department will inform the patient of his/her eligibility for Financial Assistance, and the amount of such Financial Assistance, within five (5) business days of the determination.

3. A determination of eligibility under this Policy will be effective for one (1) year. At the end of such time period, patients continuing to require essential medical services will be expected to re-apply or update their prior applications, in order to permit the Hospital to make a new determination regarding the patient's continuing eligibility for Financial Assistance.

V. COMMUNICATION

The Hospital will communicate the availability of Financial Assistance to its patients and the general public through measures that include providing or posting copies of this

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Policy, summaries thereof (if more conducive to patient understanding), appropriate signage and/or brochures:

- On the Hospital's website;
- In the Hospital's Emergency Department;
- In the Patient Registration and Admissions areas;
- In the Patient Financial Services Department;
- In other waiting areas throughout the Hospital premises (as may be reasonably workable and appropriate);
- In patient informational binders included in patient rooms; and
- In bills and statements sent to patients.

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As provided above, Patient Registration staff and Patient Financial Counselors will ensure that all self-pay patients are notified regarding the availability of Financial Assistance per the terms of this Policy.

Pertinent materials will be provided in English, Portuguese, and Spanish, which are the languages appropriate to the community served by the Hospital. All such materials will include pertinent contact telephone numbers and/or e-mail addresses to permit patients appropriate resources for completion of the Worksheet and answers to any other questions they may have about the Hospital's Financial Assistance Program.

VI. DOCUMENTATION AND RECORDKEEPING

A. The Financial Services Department will maintain all documentation of Financial Assistance within the Hospital's Financial Assistance file. The Financial Assistance file will include a cumulative total of Financial Assistance cases, together with supportive documentation. Supportive documentation will include, at a minimum, the following:

- The number of applicants for free and reduced cost services;
- The number of approved applicants;
- The total and average charges and costs of the amount of free and reduced cost care provided;
- Any other information required by, or necessarily to permit complete and accurate reporting under, applicable federal and state laws (including without limitation CT Public Act 03-266).

B. The Director of Patient Access and Financial Services will review the status of the Financial Assistance program with the Chief Executive Officer, or his/her designee, on a regular basis. The Chief Executive Officer or his/her designee will be responsible for presenting this Financial Assistance Policy to the Board of Directors at least annually. Such presentation will include a detailed statement on what the Hospital's policy is on Financial Assistance, the impact of this Financial Assistance Policy on Hospital operations and the level of need and

benefits being conferred to the community under the Hospital's Financial Assistance program.

C. Information about the amount of Financial Assistance provided will be provided in accordance with federal and state laws and regulations on reporting information under the Hospital's Financial Assistance Policy.

VII. PATIENT RIGHTS AND RESPONSIBILITIES

A. To be eligible for Financial Assistance, the patient must cooperate with the Hospital by providing the necessary information and documentation necessary to apply for appropriate federal and state governmental assistance and other financial resources that may be available to pay for his/her health care. Prior to being considered eligible for Financial Assistance from Danbury Hospital, the patient must apply for all other appropriate sources of financial assistance. Western Connecticut Health Network will assist patients with making such applications by providing assistance in completing the relevant forms and by assisting the patient with understanding how his/her income and assets relate to the Hospital's Charitable Assistance Guidelines. Consistent with this Policy, where the Hospital is aware that a patient will not qualify for a particular type of federal or state governmental assistance (e.g., based upon citizenship), the Hospital may waive the requirement that the patient apply for such assistance prior to becoming eligible for Financial Assistance.

B. Any request for Financial Assistance will be made by or on behalf of a patient. Patients may apply for, and will be encouraged to apply for, Financial Assistance before, during or within a reasonable time after Hospital care is provided. In the event a patient does not initially qualify for any Financial Assistance, the patient may re-apply upon a showing of change in circumstances.

C. Patients who are deemed eligible for any Financial Assistance must: (i) cooperate with the Hospital to establish a reasonable payment plan, which will take into account all available income and assets, the amount of the discounted bill and any prior payments; and (ii) make good faith efforts to honor any agreed-to payment plan for their discounted Hospital bills. Patients who fail to make payments according to their established payment plans will be

contacted by the Hospital by telephone and in writing to address the circumstances; in such cases, Hospital Financial Counselors will work with patients to establish a modified payment plan suitable to the patient's needs and resources. However, if a patient refuses contact from the Hospital or otherwise fails to respond after repeated efforts by the Hospital over a reasonable time period, the Hospital may submit a patient's account to collection. In that context, collection measures may include garnishment, liens (including on residences) and other practices consistent with applicable law. *[Note: Consider instead adding these provisions to the Billing and Collection Policy.]*

D. Patients are responsible for communicating to the Hospital any change in financial status that may adversely impact their ability to pay their discounted Hospital bill or to honor the provisions of their payment plans. Similarly, in the event that a patient's financial circumstances become more favorable while receiving assistance under the Hospital's Financial Assistance program, the patient will be required to notify the Hospital of such change in circumstances.

FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES

Based on 2014 Federal Poverty Guidelines

Family Size	Federal Poverty Guidelines (2013)	250% - 400 % (or Below) Poverty Guidelines *(100% write-off)*	400% - 500% Poverty Guidelines *(50% write-off)*	500% to 600% Poverty Guidelines *(30% write-off)*
1	$11,670	$29,175 to $46,680	$46,681 to $58,350	$58,351 to $70,020
2	$15,730	$39,325 to $62,920	$62,921 to $78,650	$78,651 to $94,380
3	$19,790	$49,475 to $79,160	$79,161 to $98,950	$98,951 to $118,740
4	$23,850	$59,625 to $95,400	$95,401 to $119,250	$119,251 to $143,100
5	$27,910	$69,775 to $111,640	$111,641 to $139,550	$139,551 to $167,460
6	$31,970	$79,925 to $127,880	$127,881 to $159,850	$159,851 to $191,820
7	$36,030	$90,075 to $144,120	$144,121 to $180,150	$180,151 to $216,180

**** For family units with more than 8 members, add $4,060.00 for each additional member.**

Note: This Exhibit shall be updated from time to time to reflect the most current FPGs issued by the U.S. Department of Health and Human Services.

EXHIBIT 2

PATIENT/PAYMENT SOURCE FINANCIAL WORKSHEET

Patient Name:_____ **Account Number:**_____
Household Size:_____

1A Calculation of Available Income

Monthly Salary/Pension	_____ x 12	_____
Monthly SSI/VA	_____ x 12	_____
Income Total	_____ x 12	_____ (AA)

1B Calculation of Monthly Expenses

Rent	_____	
Electric	_____	
Gas	_____	
Telephone	_____	
Water	_____	
Car Payments	_____	
Credit Cards	_____	
Insurance	_____	
Other _____	_____	
Food ($100.00 x dependents)	_____	
Monthly Expense Total	_____	
Expense Total		_____ x 12 _____ (BB)

1C Eligible Income for Hospital Bills _____ (CC)
(AA – BB) (if less then 0, enter 1)

1D Estimate Hospital Billing to Patient _____ (DD)

1E Identification of Liquid Assets

Bank Accounts	_____
Bonds	_____
Stocks	_____
CD's	_____
Mutual Funds	_____
Liquid Asset Total	_____ (EE)

1F Total Patient Due Minus Liquid Assets (DD- EE) _____ (FF)

1G Eligible Income Minus Patient Due (CC-FF) _____ (GG)
Note: If GG is a negative number, then patient will have no financial responsibility.

_____

_____ **I attest that the above information is correct.**

_____ **I attest that the Patient/Payment Source is unemployed and cannot provide employment documentation.**

_____ _____
Signature of Patient/Payment Source **Date**

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EXHIBIT 3

FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION FORM

Date: _____

Western Connecticut Health Network has conducted an eligibility determination for Financial Assistance for:
Name: _____

Medical Record Number: _____

The completed request for Financial Assistance was submitted by the patient or on behalf of the patient on: _____

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made.

_____ Your request for Financial Assistance has been denied because your income and available assets exceed those set forth in Danbury Hospital's Financial Assistance Guidelines.

_____ Your request for Financial Assistance has been approved for services rendered on_ _____. The entire balance will be treated as free care.

_____ Your request for Financial Assistance has been approved in accordance with the criteria under P.A. 03-266 for services rendered on _____.

_____ You qualify for a discount on charges consistent with the Hospital's sliding scale. This office will contact you to establish a payment plan.

_____ Your request has been denied for the following reason:

_____

_____

_____ Other (please described in detail):

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If you have questions about this determination, please contact:

_____at (203) _____, extension _____.

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Western Connecticut Health Network
FINANCIAL POLICY
CREDIT AND COLLECTION

I. GENERAL

A. Confirmation of Payment Source. To ensure adequate reimbursement to meet operating needs, WCHN (the "Western Connecticut Health Network") requires payment or proof of the ability to pay at or before the time of service. Consistent with its charitable mission, however, the Network will not deny medically necessary care because of a lack of financial information or financial resources. The Network may delay or deny elective care if financial resources are not properly identified.

B. Referral for Collection. In general, it is the Network's policy that accounts not paid within ninety (90) days will be reviewed for appropriate collection action. However, no account will be sent to collection until reasonable efforts have been undertaken to determine whether the patient is eligible for free or discounted care pursuant to the Network's Financial Assistance Policy.

C. Write-Off of Uncollectible Accounts. No later than sixty (60) days after review, accounts deemed uncollectible will be written-off.

D. Terminology. For purposes of this Policy, the term "patient" is used with regard to the patient or the applicable payment source for the patient's care (*e.g.*, parent, guardian or other responsible party).

II. ASSIGNMENT OF BENEFITS

A. Medicare – With proper identification, the Network will accept Medicare assignment for covered services. Deductibles and co-pays are due in accordance with federal regulations. Non-covered services, with proper notification, are payable at the time of service or billing. The Network recognizes its responsibility to provide notice of non-coverage.

B. Contracted Payors (*e.g.*, Blue Cross) – With proper identification, the Network will accept payor assignment for covered services. Deductibles and co-pays are due in accordance with the relevant payor agreement then in force. Non-covered services, with proper notification, are payable at the time of service or billing. The Network recognizes its responsibility to provide notice of non-coverage.

C. Medicaid – With proper identification, the Network will accept Medicaid assignment for covered services.

D. Other Third-Party Coverage – With proper identification, the Network will, as a courtesy, bill other non-contracted third-party payors. Since the Network does not have a contractual relationship with these payors, the Network considers the patient ultimately responsible for payment. The Network will wait a maximum of

sixty (60) days from initial billing for third-party payment; thereafter, any outstanding balance immediately becomes a patient responsibility. After one hundred twenty (120) days, all outstanding balances are immediately due from the patient. The Network may, in its discretion, wait another thirty (30) days if the patient and/or third-party payor shows a good faith effort to expedite payment.

E. Self-Pay Obligations – As noted above, the Network will not deny necessary care because of a lack of financial resources. However, self-pay obligations are payable at the time of service or billing. The Network will assist a patient in obtaining available third-party coverage. Additionally, the Network will provide a credit review to determine if extended credit terms are warranted. In all cases, self-pay patients will be informed of the availability of free or discounted care pursuant to the Network's Financial Assistance Policy. In connection with its services to uninsured patients, the Network will at all times abide by applicable provisions of federal and state law, including without limitation as set forth in the Network's Financial Assistance Policy.

III. DELAY/DENIAL OF CARE

A. Conditions for Delay/Denial of Care. The Network will not delay or deny medically necessary care because of a lack of financial information or financial resources. However, the Network may delay or deny elective care if financial resources are not properly identified.

1. Inpatient and One Day Surgical Admissions – The patient, admitting physician, chief of service and the operating room (if necessary) will be notified as soon as possible of any admission delayed or denied for financial reasons.

2. Outpatient – The patient, the department requested to provide service, and the referring physician will be notified as soon as possible of any treatment or services delayed or denied for financial reasons.

B. Determination of Medical Necessity. Issues regarding determination of medical necessity will be resolved between the attending (referring) physician and the chief of service.

IV. ADMINISTRATION OF POLICY

The Network's Business Office will administer and implement this Policy and will assume the following responsibilities:

A. Undertaking credit analysis to assess patients' ability to pay;

B. Ensuring that patients are aware of the availability of free or discounted care pursuant to the Network's Financial Assistance Policy and, as appropriate, assisting patients in preparing the appropriate application and supporting materials;

C. Providing additional guidance and assistance to patients through trained financial counselors;

D. Collaboratively working with patients to establish payment arrangements that are fair, equitable, and realistic in light of each patient's available financial resources;

E. Following up with patients or payors regarding the status of delayed or delinquent payments;

F. Recommending write-offs for accounts deemed to be uncollectible;

G. Recommending referrals to outside collection agencies, where appropriate; and

H. Recommending collection litigation in appropriate circumstances, after consultation with the Network's legal counsel.

V. COLLECTION

A. Measures Prior to Collection Agency Referral. Prior to referring any patient account to an external collection agency or initiating any legal action against an individual patient (or the patient's estate), the Network will take reasonable measures to confirm both of the following:

1. That no alternative payment sources exist (whether through insurance, governmental programs, or family or other parties having legal responsibility for payment), or that all alternative payment sources have been exhausted; and

2. That the Network has provided the patient with at least three (3) separate written communications specifically stating the following:

   - Whether the Network deems the patient an insured patient or uninsured patient, and the reasons for each such determination;

   - That the patient may qualify for free or discounted care pursuant to the Network's Financial Assistance Policy, with reasonable instructions regarding the process for applying thereunder; and

   - That the Network is willing to work with the patient in establishing payment arrangements that are fair, equitable and realistic in light of the patient's available financial resources.

B. Permissible Collection Agencies. The Network may refer patient accounts to one or more established, reputable debt collection agencies, provided that each such agency has provided the Network with written confirmation that such agency:

1. Will utilize only those collection techniques specifically permitted by the Network, whether pursuant to this Policy or otherwise;

2. Will not utilize any collection techniques specifically prohibited by the Network pursuant to this Policy; and

3. Will otherwise abide by applicable federal and state law.

The Network will not refer any patient account to a collection agency that has failed to provide the foregoing written confirmation. In addition, the Network will immediately terminate its relationship with any agency that has provided such a confirmation but fails to adhere thereto.

C. Collection Techniques.

1. Network to Specify. The Network will specifically instruct (whether by providing a copy of this Policy or otherwise) every collection agency it retains regarding debt collection techniques that are expressly permitted, and those that are expressly prohibited, in pursuing collection of patient accounts on behalf of the Network.

2. Permitted Collection Techniques. Permitted collection techniques include:

- Telephone calls
- Written correspondence
- Skip tracing
- Wage garnishment
- Liens on assets (including but not limited to primary residences) *[consider refraining from primary residence]*
- Small claims or other legal actions
- Other techniques permitted by law and not expressly prohibited below

3. Required Written Statements. In at least two of its written communications with patients, the agency must specifically state the following:

- Whether the Network deems the patient an insured patient or uninsured patient, and the reasons for each such determination;

- That the patient may qualify for free or discounted care pursuant to the Network's Financial Assistance Policy, with reasonable instructions regarding the process for applying thereunder; and

- That the Network is willing to work with the patient in establishing payment arrangements that are fair, equitable and realistic in light of the patient's available financial resources.

4. Prohibited Collection Techniques. A collection agency working on behalf of the Network may not do any of the following:

- Harass, oppress or abuse any person;
- Threaten to have the patient arrested for non-payment of debts;
- Falsely imply that they are attorneys or government representatives;
- Falsely imply that the patient has committed a crime;
- Falsely state that they operate or work for a credit bureau;
- Misstate the amount of the patient's debt;
- Misrepresent the involvement of an attorney in connection with collecting amounts owed;
- Indicate (i) that papers being sent are legal forms when they are not, or (ii) that papers being sent are not legal forms when they are;
- Threaten any collection action or measure not permitted by law;
- Provide false credit information about the patient to a third party;
- Use a false name; or
- Use any other collection methods prohibited by law.

SELF-PAY COLLECTION PROCESS

Pure Self-Pay (F/C P) Inpatient and Outpatient Accounts:

Timeline:

One day after blue & white bill, system sends Letter 94 "uninsured letter" to guarantor (OP) and Letter 95 "uninsured letter" to inpatients.

Fifteen days (IP) or thirty days (OP) from the first blue and white bill, patient balance > $24.99, system sends statement to guarantor.

Thirty days from last statement, patient balance between $25.00 and $2499.99, system sends final notice letter to guarantor. (For account balances > $2499.00 collector follows up manually)

Thirty days from final notice letter, patient balance between $25.00 and $2499.99, system changes financial class to Z, which is pre bad debt (Sits in Z for 3 weeks then changes to FC G).

- **Charges are reviewed for accuracy.**

- **All accounts are reviewed by entering Medical Record Number into the patient accounting system. Each account is assessed for insurance information or programs available through Danbury Hospital or outside agencies such as charity, grants, eligibility under Public Act 03-266, or Medicaid. If insurance information is found, the status is reviewed for payment or denial. If denied, the reason for denial is identified and the account is assessed for potential resubmission. All notes on other accounts are reviewed for any information that may be helpful in the collection of all outstanding accounts.**

- **If no insurance information is identified, an inpatient final bill is mailed to the guarantor with a letter and a copy of the summary letter detailing charity policies and the qualifications for P.A. 03-266 (see attached). Outpatient bills are sent without a letter, however the summary letter detailing charity policies and qualifications for P.A. 03-266 is sent separately.**

- **The guarantor is contacted for payment in full, settlement in full, or time payments. If the guarantor indicates they are unable to pay or cannot meet Danbury Hospital's time payment policy, the guarantor is referred to the Financial Counselor for assessment for other programs, i.e. Medicaid, charity, P.A. 03-266. If the account balances for the outstanding accounts are less than $500.00 each, the account is reviewed for small balance charity. For all inpatient and outpatient surgery accounts the financial counselor's**

notes are reviewed. If there are no notes from the financial counselor, the supervisor in financial counseling is contacted for review.

- All self-pay inpatient and outpatient surgery accounts with account balance over $2,499.99 are reviewed by the collection team. The financial counselor should have worked these accounts and documented their assessment. All accounts identified for Atty Simko by the financial counselor are referred to Attorney Simko by the Collection Team after review with the Managers of Patient Access and Patient Financial Services.

- If the guarantor cannot be reached at home or if there is no home telephone available, the place of employment is contacted if applicable. If guarantor cannot be reached at employment or is unemployed, an attempt is made to contact all "Emergency Contacts" identified in Patient Management.

- If a message is left for the guarantor, a follow-up call is made within 48 hours.

- A contact letter is mailed for all accounts where the collector has been unsuccessful in reaching the guarantor. (See attached)

- Property ownership and assets are verified for all patients with cumulative balances greater than $2499.99.

- Once all collection efforts have been exhausted, a final notice letter is mailed to the guarantor. (See attached)

- Provided that all collection efforts have been exhausted, and a final notice has been sent to the guarantor, the account is reviewed with the Managers of Patient Access and Patient Financial Services for approval for referral to CCI, Attorney Simko or Attorney Tobin.

- If insurance information is identified, the insurance coverage is verified via the appropriate web site or with the carrier directly. If insurance is valid, the final bill and the letter are discarded and the verified insurance information is entered into the patient management system. Support Services is contacted for a new account generation.

Self-Pay Balance after Insurance or Insurance Rejection (F/C U & M) Inpatient and Outpatient Accounts

Timeline FC U:

Thirty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends statement to guarantor.

Sixty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends final notice letter to guarantor.

Ninety days from last financial class change, patient balance > $24.99, response code not J or K system changes financial class to Z (Bad Debt) (Z will change to G in 3 weeks)

Insurance 1 paid today, total insurance balance < 0, System transfers credit balance to Patient Column

Timeline FC M:

Thirty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends statement to guarantor.

Sixty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends statement to guarantor.

Ninety days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends final notice letter to guarantor.

One hundred twenty days from last financial class change, response code not J or K, patient balance > $24.99, total insurance balance=0, system transfers to financial class X (Medicare bad debt). *(Will follow Siemen's Bad Debt Rules)*

- The patient responsibility is verified via the explanation of benefits, the payer remittance, or the appropriate website.
- If the claim is denied for "information requested from member" the guarantor is contacted for the requested information which is then submitted to the insurance carrier. If the patient must respond directly to the insurance carrier, the guarantor is advised to contact the insurance carrier.

If the claim is denied for "info requested from the provider", the requested information is identified and the account is resubmitted.

- If the claim is denied "patient responsibility" the guarantor is contacted for payment in full, settlement in full or time payments. If the guarantor indicates they are unable to pay, or cannot meet Danbury Hospital's time payment policy, the collector will refer the guarantor to the Financial Counselor for assessment for other programs such as Medicaid, charity, or P.A. 03-266. If the account balances for the outstanding accounts are less than $500.00 each, they are reviewed for small balance charity.

- If the guarantor cannot be reached at home or if there is no home telephone available, the place of employment is contacted if applicable. If guarantor cannot be reached at employment or is unemployed, an attempt is made to contact all "Emergency Contacts" identified in Patient Management.

- If a message is left for the guarantor, a follow-up call is made within 48 hours. A contact letter is mailed for all accounts where the collector has been unsuccessful in reaching the guarantor. (See attached)

- Property ownership and assets are verified for all patients with cumulative balances greater than $2499.99.

- Provided that all collection efforts have been exhausted, and a final notice has been sent to the guarantor, the account is reviewed with the Managers of Patient Access and Patient Financial Services for approval for referral to CCI, Attorney Simko or Atty Tobin.

Non-Contracted Insurance Timeline (F/C 4) Inpatient and Outpatient Accounts

Timeline FC 4:

Thirty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends statement to guarantor.

Sixty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends final notice letter to guarantor.

Ninety days from last financial class change, patient balance > $24.99, response code not J or K system changes financial class to Z (Bad Debt) (Z will change to G in 3 weeks)

Insurance 1 paid today, total insurance balance < 0, System transfers credit balance to Patient Column

Insurance 1 paid today, total insurance balance < 0, System transfers credit balance to patient column
(If patient balance is > $24.99, then system changes FC to U and sends statement to patient)

- **The insurance carrier is contacted to verify if the account was received and to identify why the claim was not processed.**
- **If the carrier indicates the claim is not on file, the subscriber's name, the insurance ID #, the group name and number if necessary, and the carrier address are verified. The Patient Management/Patient Accounting system is updated with the corrected information and, if necessary, the account is referred to the billing department for resubmission.**
- **If the carrier has denied the claim patient responsibility, the carrier is asked to either fax or send the denial.**
- **The denial is posted in patient accounting and forwarded to document imaging.**
- **The process for pure self-pay collections is followed as stated above.**

Revised 09/28/09

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Services

Kevin's Community Center Clinic provides coordinated, comprehensive, personalized primary health care on a first-contact basis, incorporating medical diagnosis and treatment and personal support. The Clinic also supplies information about illness, including the prevention of disability and disease through early detection, education and treatment. These responsibilities, in conjunction with the evaluation and appropriate referral of patients who require specialist evaluation and treatment, comprise the scope of practice for Kevin's Community Center Clinic.

- **Free primary health care**
- **Free Diabetes Clinic & Education**
- **Free Laboratory & Radiological Services**
  Services are offered through the generous support of Danbury Hospital and Housatonic Valley Radiological Associates.
- **Free Referral Specialty Care**
  Our network of referrals include over 100 specialists from the greater Danbury area and the Danbury Office of Physican Services who donate their time.
- **Prescription Medications**
  Most prescription medications are offered free of charge through our stock samples. The balance is offered at cost through the Drug Center Pharmacy of Newtown and through our patient assistance programs. To keep costs down we also take advantage of the generic Rx programs offered by many pharmacies.

We see both scheduled and walk-in patients each Wednesday afternoon from 1 P.M. – 5 P.M.
Appointments may decrease wait time.

- **Upcoming KCC Events**

Feb 21 2015 - RTD: Healthy Hearts

Mar 21 2015 - RTD: Colorectal Cancer

Eligibility Requirements

Our mission is to provide free primary health care for persons over the age of 18 who are uninsured or under-insured and who have limited financial resources. Patients, therefore, must meet the following eligibility criteria in order to be seen at the clinic.

- You must be uninsured or under-insured
- Your income must fall within the centers guidelines. Individuals are "Eligible" for free medical services at KCC if they have household incomes between 100% and 200% of the Federal Poverty Level (FPL). Individuals are "restricted" or possibly eligible on a case by case review if their household income is between 200% and 300% FPL. Please call the clinic for more information if you are not sure you qualify.
- You must provide proof of residence in one of the following towns:

Newtown	**Sandy Hook**	**Botsford**	**Hawleyville**
Dodingtown	**Roxbury**	**Bridgewater**	

Kevin's Community Center has limited resources and cannot provide care to all those in need. The clinic will, therefore, give priority to those patients who demonstrate their willingness and determination to forge a real partnership, working together to improve their health status.

- We will not treat abusive or abrasive patients.
- We will not treat patients under the influence of drugs or alcohol.
- We expect patients to come to the clinic clean and appropriately dressed.
- We expect patients to be compliant with their medical treatment as prescribed.
- We expect patients to be honest about their medical, financial and insurance status.

If any of the above expectations are violated, Kevin's Community Center reserves the right to terminate services immediately, either temporarily or permanently. In such cases, a copy of the

patient's records will be made available, at the patient's request, to the health care provider of his/her choice.

- **Upcoming KCC Events**

  Mar 21 2015 - RTD: Colorectal Cancer

  Apr 18 2015 - RTD: Alcoholism

  May 16 2015 - RTD: Mental Health

  Jun 20 2015 - RTD: Skin/Melanoma

  Jul 18 2015 - RTD: Lyme Disease

- **What's new at KCC**
  - Community Outreach Program

- **Contribute to KCC**

Donate Volunteer

Many methods available to you for donating to support our cause such as: Paypal, Garden of Friends, Seeds of the Future, In Leiu of Flowers and Car Donations (VDAC)

Learn More...

- **KCC Building Project**

Read more...

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Raw Data *February 2015*

Federal Poverty Guidelines

The new 2015 federal poverty guidelines have been released. The 2014 guidelines are also provided here for reference.

It's important to note that eligibility for Medicaid and the Children's Health Insurance Program (CHIP) is now determined by the 2015 guidelines. Eligibility for advance premium tax credits is determined by 2014 federal poverty guidelines.

State-run health insurance marketplaces should update their standards as soon as possible to align with those of the federally facilitated marketplaces. A short explanation of what these changes mean to consumers is here (via Center for Children and Families).

2015 Federal Poverty Guidelines

Federally facilitated marketplaces will use the 2015 guidelines to determine eligibility for Medicaid and CHIP.

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$11,770	$15,654	$17,655	$23,540	$29,425	$35,310	$63,720
2	15,930	21,187	23,895	31,860	39,825	47,790	63,720
3	20,090	26,720	30,135	40,180	50,225	60,270	80,360
4	24,250	32,253	36,375	48,500	60,625	72,750	97,000
5	28,410	37,785	42,615	56,820	71,025	97,710	113,640

6	32,570	43,318	48,855	65,140	81,425	110,190	130,280
7	36,730	48,851	55,095	73,460	91,825	110,190	146,920
8	40,890	54,384	61,335	81,780	102,225	122,670	163,560

2015 Alaska Poverty Guidelines

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$14,720	$19,578	$22,080	$29,440	$36,800	$44,160	$58,880
2	19,920	26,494	29,880	39,840	49,800	59,760	79,680
3	25,120	33,410	37,680	50,240	62,800	75,360	100,480
4	30,320	40,326	45,480	60,640	75,800	90,960	121,280
5	35,520	47,242	53,280	71,040	88,800	106,560	142,080
6	40,720	54,158	61,080	81,440	101,800	122,160	162,880
7	45,920	61,074	68,880	91,840	114,800	137,760	183,680
8	51,120	67,990	76,680	102,240	127,800	153,360	204,480

2015 Hawaii Poverty Guidelines

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$13,550	$18,022	$20,325	$27,100	$33,875	$40,650	$54,200
2	18,330	24,379	27,495	36,660	45,825	54,990	73,320
3	23,110	30,736	34,665	46,220	57,775	69,330	92,440
4	27,890	37,094	41,835	55,780	69,725	83,670	111,560
5	32,670	43,451	49,005	65,340	81,675	98,010	130,680
6	37,450	49,809	56,175	74,900	93,625	112,350	149,800

7	42,230	56,166	63,345	84,460	105,575	126,690	168,920
8	47,010	62,523	70,515	94,020	117,525	141,030	188,040

2014 Federal Poverty Guidelines

Federally facilitated marketplaces will use the 2014 guidelines to determine eligibility for Medicaid and CHIP (this is effective February 10, 2014).

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$11,670	$15,521	$17,505	$23,340	$29,175	$35,010	$46,680
2	15,730	20,921	23,595	31,460	39,325	47,190	62,920
3	19,790	26,321	29,685	39,580	49,475	59,370	79,160
4	23,850	31,721	35,775	47,700	59,625	71,550	95,400
5	27,910	37,120	41,865	55,820	69,775	83,730	111,640
6	31,970	42,520	47,955	63,940	79,925	95,910	127,880
7	36,030	47,920	54,045	72,060	90,075	108,090	144,120
8	40,090	53,320	60,135	80,180	100,225	120,270	160,360

Source: Calculations by Families USA based on data from the U.S. Department of Health and Human Services

Key Issues:

Affordable Care Act

Topics:

Premium Tax Credit

States:

50 States

A special note to the disabled: To ensure that no individual with a disability is denied access as described by the Americans with Disability Act, please call a clinic prior to your arrival.

Services We Provide

- ✓ **Diagnosis and treatment** of non-urgent and chronic medical conditions;
- ✓ **Essential medications** as available;
- ✓ **X-ray and diagnostic services** as indicated and as available;
- ✓ **Laboratory tests** ordered by AmeriCares physicians;
- ✓ School and pre-employment **physical exams.** These must be scheduled in advance with the clinic director. We will not do DMV licenses, or physicals that require examination outside of the range of clinic services.
- ✓ **Immunizations** for children *(Norwalk location only)* and adults as available;
- ✓ **Referrals** to specialty care and procedures when available; some providers may charge for services.

Services We Cannot Provide

- ✗ **Emergency care for** urgent medical problems or traumatic injuries;
- ✗ **Nonessential medications, diagnostic and laboratory testing and referrals;**
- ✗ **Dental care;**
- ✗ **Mental Health/Psychiatric** or substance abuse treatment, including medications;
- ✗ Certain medications, including narcotics, tranquilizers, and sleeping aids.
- ✗ Medical care for women during **pregnancy**;
- ✗ Care related to conditions associated with workman's compensation, disability cases, second opinions or ongoing or potential litigation;
- ✗ Care for tuberculosis, STDs and HIV/AIDS;
- ✗ Care for some complex medical problems beyond our scope of services.

76 West Street
Danbury, CT 06810

Get Directions

88 Hamilton Avenue · Stamford, CT 06902 · (800) 486-HELP · (203)-658-9500 · freeclinics@americares.org · Privacy Policy (http://www.americares.org/afc/privacy-policy.html) · Donate (https://secure.americares.org/site/Donation2?df_id=16691&16691.donation=form1)

AmeriCares Free Clinics is a program of AmeriCares (http://www.americares.org/), the nonprofit global health and disaster relief organization.

AmeriCares Free Clinics is approved by the Internal Revenue Service as a 501 (C) (3) tax-exempt organization, and all donations are tax deductible to the extent provided by law. AmeriCares Free Clinics Federal Identification Number (EIN) is 06-1422741

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Visit other AmeriCares sites: Select Site

WHO'S ELIGIBLE?

To be eligible, patients must:

- Have no public or private health insurance
- Not be Medicaid eligible
- Meet income guidelines (see chart below (/afc/patients/#incomelvls))
- Be 18 years or older to receive care in Bridgeport, Danbury and Stamford
- Provide photo identification
- Provide income verification upon request
- Provide proof of residency (/afc/patients/#tab-2)
- Pediatric patients (Norwalk clinic only) must be accompanied by a parent or legal guardian

View Our Services (/afc/patients/#section3)

Income Guidelines | Towns Served | Clinic Expectations

Income Guidelines

For the Bridgeport, Danbury and Norwalk clinics...

The AmeriCares Free Clinics program provides health care services, free of charge, to eligible individuals with a total household income under 200% of the Federal Poverty Level. **For 2015,** this level of income would be:

Household size	Weekly income	Monthly income	Annual income
1	$453	$1,962	$23,540
2	$613	$2,655	$31,860
3	$773	$3,348	$40,180
4	$933	$4,042	$48,500
5	$1,093	$4,735	$56,820
6	$1,253	$5,428	$65,140
For Each Addl. Person, add:	$160	$693	$8,320

Please Note: You will be asked to provide proof of household income (i.e. tax returns, pay stubs, unemployment checks) in order to ensure eligibility or to help obtain medicines at no cost to you.

For the Stamford clinic...

The AmeriCares Free Clinics program provides health care services, free of charge, to eligible individuals with a total household income under 250% of the Federal Poverty Level. **For 2015,** this level of income would be:

Household size	Weekly income	Monthly income	Annual income

1	$566	$2,452	$29,425
2	$766	$3,319	$39,825
3	$966	$4,185	$50,225
4	$1,166	$5,052	$60,625
5	$1,366	$5,919	$71,025
6	$1,566	$6,785	$81,425
For Each Addl. Person, add:	$200	$867	$10,400

GET CARE.

Please note that the clinic is closed on holidays and holiday weekends. If you do not speak English or Spanish, please bring a friend or relative who can interpret on your behalf.

OUTPATIENT DEPARTMENT/FINANCIAL COUNSELORS
MATERNITY PACKAGE PLAN PRENATAL PROGRAM

The "Package Plan" fee is $1500.00 for prenatal care.

The qualification process includes an assessment to determine if the patient and / or the newborn will be eligible for any government sponsored medical assistance programs (Medicaid). The "Package Plan" fee will not be available to patients who qualify for government medical prenatal assistance.

Patients, who qualify for the package, are responsible for the $1500.00 "Package Plan" fee. Payments are to be made monthly to the Financial Counselor in the Outpatient Department. Bring all medical bills to the Financial Counselor for determination if included in the Package Plan.

Most patients who qualify for the "Package Plan" prenatal program will also qualify for Medicaid for delivery-related bills. If you qualify for Medicaid for your delivery, Danbury Hospital personnel will assist you with the Medicaid Application. If you do not follow through with a Medicaid application, you will be billed for all delivery charges.

COMPLETE PAYMENT IS REQUIRED BY THE SCHEDULED DELIVERY DATE.

If payment is not completed by the scheduled delivery date, the patient has defaulted on the "Package Plan Agreement." At that point, the patient will be responsible for total posted charges.

Covered Services

1. Prenatal outpatient services rendered in Danbury Hospital Outpatient Dept.
2. OB ultrasounds included up to, (2) scans. Further testing will be patient's responsibility.
3. Six weeks of postpartum care (outpatient services only).

No covered Services

1. Inpatient hospitalizations even if pregnancy related. These bills will be handled as routine inpatient accounts.
2. Expenses for non-Danbury Hospital physician services for mother and baby.
3. Services not related to prenatal, delivery and postpartum.
4. Inpatient hospitalizations during the six weeks of postpartum care.

I certify that I have read the above conditions and accept and agree to the terms specified.

Signature _____ Date _____

Witness _____