THE CHARLOTTE HUNGERFORD HOSPITAL
POLICY MANUAL

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

POLICY

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

PROCEDURE

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

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

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

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

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

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

APPROVED BY: Hospital Policy & Procedure Steering Committee

ORIGINATING DEPARTMENT: Finance

THE CHARLOTTE HUNGERFORD HOSPITAL

POLICY MANUAL

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

POLICY

To ensure a standardized process for handling bankruptcy notices.

PROCEDURE

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

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

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

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

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

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

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

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

Originating Entity: Financial Services

THE CHARLOTTE HUNGERFORD HOSPITAL
ADMINISTRATIVE POLICY MANUAL

FINANCE	POLICY NO: 14.P1
	DATE OF ORIGIN: 5/6/03
	DATE REVISED: 11/06/2014
	DATE REVIEWED: 11/06/2014
SUBJECT: Patient Assistance Committee	PAGE 1 OF 4

PURPOSE

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

PROCEDURE

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

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

    * b. Patients that have been set up with a contract with Clear Balance will not have that particular account reviewed with an application, unless they have defaulted on the payment plan.

2. Financial screening application will be mailed or given out by financial advocate, per patient's request. If more information is needed, a missing information letter is sent to the patient, and the patient has ten (10) business days to respond to this request, otherwise the request for financial assistance may be dismissed.

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

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

    a. In regards to the application, the following terms and definitions apply:
        i. "Family Income" - family income is defined as the total income that is available to the household; this is to include combined salaries/income of husband and wife, as well as adults engaging in co-habitation where dependent child/children are present.

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

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

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

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

iii. "Uninsured Patients" - PAC follows the definition set forth by the State of Ct to determine "Uninsured" patients with the following clarifications: patients on a Medicaid "spend-down" are also considered "Uninsured". Patients are not deemed uninsured until they have received a determination notice from DSS and were uninsured on the date of service. The definition of "uninsured" is further impacted by the Affordable Care Act, as Medicaid "spend-down" status will be limited.

iv. "Self Pay Patients" - CHH considers any patient who presents without insurance and is not eligible for Medicaid per our eligibility tool to be self-pay. As of January 2014, the Affordable Care Act requires individuals to obtain health insurance coverage. If the individual mandate is not met, the application will be reviewed on an individual basis and a determination on whether to designate as charity care will be make.

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

* Care will be provided free for those uninsured patients who qualify as uninsured and verification has determined that their annual income is less than 250% of the FPL. In January 2014, these patients should qualify for an individual insurance plan and must provide why they did not apply before going to assistance.

* Care will be provided at Hospital cost, as established by the Office of Health Care Access (OHCA), for those self-pay patients who request assistance and verification has determined that their annual income is below 250% of the FPL. See policy 14.P1A, Pre-Emptive Charity Care Adjustment.

* Care will be discounted by 30% for those self-pay patients who request assistance and verification has determined that their annual income is between 251% and 400% of the FPL.

vi. The Hospital will also consider the total medical expenses faced by a family and the family's ability to pay for those expenses, and will consider offering greater assistance when possible to those families facing catastrophic medical expenses.

vii Underinsured patients will be considered for any balances after insurance pays. Any self-pay balance elective procedure, must be reviewed by the committee, prior to services rendered.

viii. Patient referred from courts for legal accounts can apply, but will have to pay the legal fees. If the accounts are over 18 months from the last billing date, patients must provide their latest tax return, or if unavailable, their latest earnings information.

5. Patients who qualify for a reduction under Senate Bill 568 will have their accounts adjusted in accordance with Senate Bill 568 as outlined in Addendum A.

6. The PAC secretary or designee will screen all applications against utilizing family income levels (as defined above). Patients will be provided a discount based upon these guidelines if applicable. Deviations from the guidelines can be approved by PAC on a case by case basis.

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

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

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

10. In lieu of a completed application filled out by the patient, financial counselors can present cases on patient's behalf under the following circumstances:
    a. The Patient has completed three or more Medicaid applications the CHH Staff but has been denied each time for failure to provide documentation to DSS
    b. The patient is homeless and unreachable for follow up.
    c. The patient is non-citizen and unreachable for follow up.
    d. Contacting the patient for follow up could put them at risk.

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

Financial Counselor.
These discounts will be given at the committee's discretion.

11. Before patients are sent to Bad Debt, PAC reserves the right to run them through Transunion to screen for possible Charity Care. Patients who return a Transunion score below 500 will be considered for a charity care adjustment. These patients will be exempt from the above process.

    a. In addition to above, patients that have Medicare primary, and Medicaid secondary, and Medicare denies payment, these will be charity care, with an automatic adjustment put on the account using ACHARITY1. This rule will also apply if the patient has a commercial plan, and a Medicaid spend-down. If a patient is on a Medicaid spend-down, the bill will be faxed to DSS, senate bill adjustment applied, and the amount adjusted to ACHARITY1. If the spend-down is greater than $10,000, the patient must fill out a Patient Assistance application. As of January 2014, the Affordable Care Act has limited the use of a "spend down" process under Medicaid, which will impact the application of this provision.

    b. Patients with no estates, will be adjusted off to ACHARITY 1.

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

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

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

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

APPROVED BY: Hospital Policy & Procedure Steering Committee

CROSS REFERENCE: Hospital Policy 14.PA, Pre-Emptive Charity Care Adjustment

ORIGINATING DEPARTMENT: Financial Services

Revised: 07/22/2008, 04/2010, 8/2011, 12/01/2012, 12/01/2013, 03/06/2014, 11/06/2014

Reviewed: 04/20/2012

THE CHARLOTTE HUNGERFORD HOSPITAL
ADMINISTRATIVE POLICY MANUAL

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

PURPOSE

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

PROCEDURE

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

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

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

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

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

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

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

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

APPROVED BY: Hospital Policy & Procedure Steering Committee

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

ORIGINATING ENTITY: Financial Services

TOS COLLECTIONS/FINANCIAL SCREENING

Tue May 7, 2013 1:42 pm *From: Lori A. Bebyn*

ALL REGISTRARS -

The Financial Clearance information below has been updated. Effectively immediately, please refer to the new adjustments in each of the columns when determining whether a patient is SP or SPNC.

Wed Nov 28, 2012 12:50 pm *From: Lori A. Bebyn*

Effective 12/1/12 registration will screen self-pay patients for eligibility to receive the Senate Bill Adjustment. If the patient meets the income guidelines, then the adjustment will be deemed charity care. At the bottom of the insurance page (page 3.5) of the registration, you will see the following Financial Clearance questions:

FINANCIAL CLEARANCE:

- **Are you or do you have any children under the age of 19?**
- **What is your Gross Household Income (Before Taxes)?(must use a decimal point - ex-50000.00)**
- **How many people in your household?**
- **Does your household have bank accounts exceeding $10,000?**

Registrars are to ask these questions to the patient. The following is a script for cost reduction screening that you can follow:

"I see that you are a self pay patient. It is possible that you will qualify for our cost adjustment, but in order to determine that I will need to ask you for your annual income and family size. Would you like to be considered for this discount?"

If yes, then continue to fill out CDS and leave SP if qualified.

If no, then you will register as SPNC.

The family size and income criteria are listed below:

Column 1: Register patient as SPNC if income is over, declines to answer or if the patient doesn't have any info at the time of registration. If the patient is over income, then "queue" for the Financial Counselor BUT if the patient refuses to answer, don't queue.

Column 2: Register Patient as SP if income is under and if patient doesn't know & queue

Column 3: Give Patient Financial Aid if income is under and register as SP

Time of Service Collections: Self Pay

	Column 1 Column 1: Register patient as **SPNC** if income is over, declines to answer or if the patient doesn't have any info at the time of registration. If the patient is over income, then "queue" for the Financial Counselor BUT if the patient refuses to answer, don't queue.	**Column 2** Column 2: Register Patient as SP if income is under and if patient doesn't know & queue	**Column 3** Column 3: Give Patient Financial Aid if income is under and register as SP
Family Size	**Register as SPNC if income is OVER OR DECLINES to answer**	**Register as SP if income is UNDER**	**Give Patient Financial Aid Info if income is UNDER**
1	$28,725	$28,725	$22,980
2	$37,775	$37,775	$31,021
3	$48,825	$48,825	$39,060
4	$58,875	$58,875	$47,100
5	$68,925	$68,925	$55,140
6	$78,975	$78,975	$63,180
7	$89,025	$89,025	$71,220
8	$99,075	$99,075	$79,260
DISCOUNT	**20%**	**46.68%**	**46.68%**
ADDITIONAL DISCOUNT FOR PAYMENT AT TIME OF SERVICE	**15%**	**15%**	**15%**

I will be bringing copies of the Financial Assistance Application to each of the areas.
For those areas that I am unable to visit, I will be sending a copy to your Manager.

THE CHARLOTTE HUNGERFORD HOSPITAL
ADMINISTRATIVE POLICY MANUAL

FINANCE	POLICY NO:	14.C3
	DATE OF ORIGIN:	10/1/03
	DATE REVISED:	6/17/04
	DATE REVIEWED:	05/01/2013
SUBJECT: Cost Reduction Screenings for Patients	PAGE 1 OF 2	

PURPOSE

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

PROCEDURE

1. Patients will enter the screening process through the Financial Counselors in the Emergency Department, the Financial Counselor in Finance, Social Services, or self pay collection referral.

2. A determination will be made by the Hospital after a series of questions are answered by the patient as to whether they are likely to meet the "uninsured" criteria (see Attachment 1). If patients are over income, even through verbal verification, the patient may be set up on a contract.

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

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

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

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

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

6. Financial applications will be processed by the Financial Counselors. Only those patients who wish to be considered for additional assistance need to have their case documented and provided to the Patient Assistance

Committee for review at its normal monthly meeting based on the criteria in Hospital Policy 14P.1, Patient Assistance Committee.

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

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

APPROVED BY: Hospital Policy & Procedure Steering Committee - 6/17/04

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

ORIGINATING DEPARTMENT: Finance

REVIEWED: 05/01/2013 (NO CHANGES)

ATTACHMENT A - BELOW

Attachment A

ARE YOU UNINSURED?

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

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

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

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

Effective with DOS 10/1/03

According to SB 568 if a patient's income meets the criteria below based on family size - the outstanding bill will be reduced to cost (total bill x .6173).

FAMILY MEMBERS	INCOME THROUGH
1	$23,275
2	$31,225
3	$39,175
4	$47,125
5	$55,075
6	$63,025
7	$70,975
8	$78,925