Saint Francis Hospital and Medical Center
Community Assistance Program
Eligibility Criteria On or After 02/01/2015

2015 Poverty Guidelines

FAMILY SIZE	ANNUAL GROSS INCOME POVERTY	200%	250%
1	11,770	23,540	29,425
2	15,930	31,860	39,825
3	20,090	40,180	50,225
4	24,250	48,500	60,625
5	28,410	56,820	71,025
6	32,570	65,140	81,425
7	36,570	73,140	91,425
8	40,890	81,780	102,225
9	45,050	90,100	112,625
10	49,210	98,420	123,025

SLIDING SCALE

Rate

A = SELF PAY DISCOUNT only
B = PATIENT OWES MEDICARE
C = FULL ASSIST 100%

WEEKLY GROSS INCOME	MONTHLY GROSS INCOME	ANNUAL INCOME	SLIDING SCALE FAMILY SIZE									
			1	2	3	4	5	6	7	8	9	10
0 - 451	0 - 1,962	23,540	C	C	C	C	C	C	C	C	C	C
452 - 564	1,963 - 2,452	29,425	B	C	C	C	C	C	C	C	C	C
565 - 611	2,453 - 2,655	31,860	A	C	C	C	C	C	C	C	C	C
612 - 764	2,656 - 3,319	39,825	A	B	C	C	C	C	C	C	C	C
765 - 771	3,320 - 3,348	40,180	A	B	C	C	C	C	C	C	C	C
772 - 930	3,349 - 4,042	48,500	A	A	B	C	C	C	C	C	C	C
931 - 963	4,043 4,185	50,225	A	A	B	B	C	C	C	C	C	C
964 - 1,090	4,186 - 4,735	56,820	A	A	A	B	C	C	C	C	C	C
1,091 - 1,163	4,736 - 5,052	60,625	A	A	A	B	B	C	C	C	C	C
1,164 - 1,249	5,053 - 5,428	65,140	A	A	A	A	B	C	C	C	C	C
1,250 - 1,362	5,429 - 5,919	71,025	A	A	A	A	B	B	C	C	C	C
1,363 - 1,403	5,920 - 6,095	73,140	A	A	A	A	A	B	C	C	C	C
1,404 - 1,568	6,096 - 6,815	81,780	A	A	A	A	A	A	B	C	C	C
1,569 - 1,728	6,816 - 7,508	90,100	A	A	A	A	A	A	B	B	C	C
1,729 - 1,753	7,509 - 7,619	91,425	A	A	A	A	A	A	B	B	B	C
1,754 - 1,888	7,620 - 8,202	98,420	A	A	A	A	A	A	A	B	B	C
1,889 - 1,961	8,203 - 8,519	102,225	A	A	A	A	A	A	A	B	B	B
1,962 - 2,160	8,520 - 9,385	112,625	A	A	A	A	A	A	A	A	B	B
2,161 - 2,360	9,386 - 10,252	123,025	A	A	A	A	A	A	A	A	A	B

Saint Francis Hospital and Medical Center
Community Assistance Program
Eligibility Criteria On or After 02/01/2014

2014 Poverty Guidelines

FAMILY SIZE	ANNUAL GROSS INCOME POVERTY	200%	250%
1	11,670	23,340	29,175
2	15,730	31,460	39,325
3	19,790	39,580	49,475
4	23,850	47,700	59,625
5	27,910	55,820	69,775
6	31,970	63,940	79,925
7	36,030	72,060	90,075
8	40,090	80,180	100,225
9	44,150	88,300	110,375
10	48,210	96,420	120,525

SLIDING SCALE

Rate

A = SELF PAY DISCOUNT only
B = PATIENT OWES MEDICARE
C = FULL ASSIST 100%

WEEKLY GROSS INCOME	MONTHLY GROSS INCOME	ANNUAL INCOME	SLIDING SCALE FAMILY SIZE 1	2	3	4	5	6	7	8	9	10
0 - 448	0 - 1,945	23,340	C	C	C	C	C	C	C	C	C	C
449 - 560	1,946 - 2,431	29,175	B	C	C	C	C	C	C	C	C	C
561 - 603	2,432 - 2,622	31,460	A	C	C	C	C	C	C	C	C	C
604 - 759	2,623 - 3,298	39,580	A	B	C	C	C	C	C	C	C	C
760 - 915	3,299 - 3,975	47,700	A	A	B	C	C	C	C	C	C	C
916 - 949	3,976 4,123	49,475	A	A	B	B	C	C	C	C	C	C
950 - 1,071	4,124 - 4,652	55,820	A	A	A	B	C	C	C	C	C	C
1,072 - 1,144	4,653 - 4,969	59,625	A	A	A	B	B	C	C	C	C	C
1,145 - 1,226	4,970 - 5,328	63,940	A	A	A	A	B	C	C	C	C	C
1,227 - 1,338	5,329 - 5,815	69,775	A	A	A	A	B	B	C	C	C	C
1,339 - 1,382	5,816 - 6,005	72,060	A	A	A	A	A	B	C	C	C	C
1,383 - 1,538	6,006 - 6,682	80,180	A	A	A	A	A	A	B	C	C	C
1,539 - 1,694	6,683 - 7,358	88,300	A	A	A	A	A	A	B	B	C	C
1,695 - 1,728	7,359 - 7,506	90,075	A	A	A	A	A	A	B	B	B	C
1,729 - 1,849	7,507 - 8,035	96,420	A	A	A	A	A	A	A	B	B	C
1,850 - 1,922	8,036 - 8,352	100,225	A	A	A	A	A	A	A	B	B	B
1,923 - 2,117	8,353 - 9,198	110,375	A	A	A	A	A	A	A	A	B	B
2,118 - 2,312	9,199 - 10,044	120,525	A	A	A	A	A	A	A	A	A	B

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114 Woodland Street, Hartford, CT 06105

Collaborative Laboratory Services

Mount Sinai Rehabilitation Hospital
a SAINT FRANCIS *Care* Provider

APPLICATION FOR FINANCIAL ASSISTANCE

Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Social Security #: _____ Home Phone #: _____

Employer's Name & Address: _____

Number - Household Members: _____ Other Family Income: $ _____

Patient's gross income: $ _____ Total Family Income: $ _____

Service Date(s): _____ Acct #: _____ Balance: $ _____

Proof of income provided: _____ Pay stubs *(4 current)* _____ Fed'l Tax Return *(most recent)* _____ Other: *SSI, State denial*

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

I understand that this application is made so that the hospital can judge my eligibility for Financial Assistance, based on the established criteria of the hospital. If any information I have given proves to be untrue, I understand the hospital may re-evaluate my financial status and take whatever action is appropriate.

I also understand that all information requested must be received within ten (10) working days from date of request.

_____	_____	_____
Date of request	Person Completing Application	Applicant's signature

---

ELIGIBILITY DETERMINATION *(For Office Use Only)*

Date application received: _____ Documentation received: _____

The applicant is **eligible** for % _____ = $ _____ Financial Assistance Funds. New balance: $ _____.

_____ The applicant's request for Financial Assistance Funds have been **denied** for the following reason(s):

_____ Over-income _____ Did not pursue available resources or failed to comply _____ No income

_____ Other reason: _____

Date determination (deny/eligible): _____ Authorized Signature: _____

3904313 8/29/14

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Financial Assistance

Patient **must** supply the following documentation in order to determine eligibility:

An application for State Medical Assistance (Medicaid) must be completed for those patients with verified income below 100% poverty guideline. If your request for State assistance is denied, obtain a copy and attach it to your completed Financial Assistance Application.

Attach proof of income for the last twelve (12) months for you and your spouse. (Federal Tax Return, most current date).

Attach copy of unemployment, pension, voucher, social security or disability benefits *(if applicable)*.

Provide social security numbers for all dependents listed in the number of family size, if they are not listed on your last Federal Tax Return. Birth certificates may also be requested.

For ***undocumented citizens***, the procedure to grant Financial Assistance Funds are as follows:

Copy of alien status; passport/visa. If you are a permanent resident, but in the US for less than five (5) years, you are ***not*** eligible for State Assistance.

However, your sponsor **IS** responsible for any financial or medical services that are provided to you. If you have no means to pay this hospital debt and are applying for assistance, you **must** furnish us with your **sponsor's income** to determine your eligibility. Using the same criteria as listed above without the need for State denial. This information must also be received within ten (10) business days from received date or application will be denied.

Any questions or concerns, please feel free to call our office, Monday through Friday; 8:00am - 4:00pm at 860-714-4952. Thank you.

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El Hospital Saint Francis proporciona asistencia financiera a las personas que califican a base de los ingresos del hogar y tamaño de la familia. Sin embargo, si su ingreso es menor que el nivel federal de pobreza, necesitamos una carta de rechazo por parte del Estado en cual usted vive o prueba de que usted ya está recibiendo asistencia publica del Estado.

Adjunto encontrará una solicitud para ayuda financiera que necesita completar y devolver junto con una copia de los últimos cuatro (4) talonarios consecutivos para todos los miembros del hogar y una copia de su última declaración de impuestos federal.

Por favor envíe su solicitud a:
Saint Francis Hospital
Atencion: Patient Accounts
114 Woodland Street
Hartford, CT 06105

Si usted tiene preguntas o preocupaciones, por favor póngase en contacto con un representante para asistencia al (860) 714-4952 de lunes a viernes entre las 8:00am-4:00pm.

Gracias por elegir al Hospital Saint Francis y Centro Médico para su servicio.

Cordialmente,

Cuentas de Pacientes
860-714-4952

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Mount Sinai Rehabilitation Hospital
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APLICACIÓN PARA ASISTENCIA FINANCIERA

Nombre: _____

Dirección: _____

de Seguro Social: _____ # de telefono: _____

Nombre y dirección del empleador: _____

Numero de dependientes: _____ Ingreso de otros familiares: _____

Ingreso del paciente: _____ Ingreso total de la familia: _____

Fecha(s) de servicio: _____ # de cuenta: _____ Saldo: _____

Prueba de ingreso: _____ Talonarios *(4 recientes)* _____ Forma de Impuestos *(recientes)* _____ Otros: *SSI, State negación)*

Certifico que la información suminstrada es cierta segun mi leal saber. Ademas, haré cualquier aplicación para asistencia *(medicaid, medicare, seguros, etc.)* las cuales servirán para cubrir las deudas del hospital. Tomaré cualquier acción que sea razonablemente necesaria para obtener dicha asistencia.

Yo entiendo que esta aplicación esta hech para que el hospital pueda juzgar mi elegibilidad para asistencia financiera, basados en el criterio establecido en los archivos del hospital. Si cualquier información que yo haya proveido prueba ser falsa, yo entiendo que el hospital reevaluara mi estado financiero y tomará la acció que sea apripiada.

Entiendo que la prueba de ingreso debe ser sometida dentro de dias (10) laborables ha partir de la fecha del pedido.

_____ _____ _____

Fecha del Pedido Persona Completando la Aplicación Firma del Aplicante

---

DETERMINACIÓN DE ELEGIBILIDAD *(uso de la oficina)*

Fecha de haber recibido la aplicación: _____ Verificación de Ingreso: _____

El/La aplicante es elegible para % _____ = $ _____ ayuda financiera. Saldo actual: $ _____

El/La aplicante es elegible para _____ % ayuda financiera

_____ El pedido del aplicante para servicios gratis o reducidos ha sido negado por la(s) razone(es) siguientes:

_____ Sobre Ingreso _____ No aplicó para los recursos disponibles _____ Ningun Ingreso

_____ Otros: _____

Fecha Determinante de elegibilidad: _____ Firma Autorizada: _____

3904314 8/29/14

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Ayuda Financiera

Los pacientes **deberán** presentar los siguientes documentos para poder determinar su elegibilidad:

Una solicitud del Departamento de Servicios Sociales debe ser completeda para los pacientes con un ingreso menor de 100% de los estándares de pobreza. Si su solicitud para servicios sociales es denegada, favor de obtener una copia y adjúntela a su solicitud de Ayuda Financiera que ofrece el hospital.

Envie prueba de ingreso de los últimos 12 meses de usted y su conyugue. Esto es la Planilla Federal de Impuestos con las fecha más reciente (Federal Tax Return).

Envie una copia de los últimos 4 talonarios (suyos y de su conyugue), desde el dia en que la aplicación para Asistencia Financiera del Hospital fue completada.

Si está desempleado y recibe beneficios, envie una copia del comprobante de beneficios de desempleo, del seguro social o de incapacidad.

Provea el número de seguro social de todos los dependientes listados en el encacillado que especifica la cantidad de personas en la familia, y que **no** aparacen en la Planilla Federal de Impuestos Contributivos (Federal Tax Return).

Para ***ciudadanos indocumentados***, el procedimiento para aprobacíon la Asistencia Financiera es como sigue:

- Usaremos el mismo criterio enlistado.
- Necesitamos una copia de su estado legal; por ejemplo, el pasaporte/visa.

Si esta información no es recibida en 10 dias, la solicitud será negada.

Cualquier pregunta, favor de llamar a nuestras oficinas de lunes a viernes de 8:00am a 4:00pm al 860-714-4952. Muchas gracias.

SAINT FRANCIS Care Policy	Title: Financial Assistance Policy		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** DEPARTMENT OF Patient Accounting	**Number**	**Level** ☐ System ☐ Division ☒ Department
	Category ☒ Administrative ☐ Clinical ☐ HR ☐ EOC	**Published Date** April 1, 2011	**Review Cycle** ☒ 1 year ☐ 3 years

PURPOSE:

It is the policy of Saint Francis Hospital and Medical Center & The Rehabilitation Hospital of CT to ensure a socially just practice for billing patients receiving care at any of its facilities. Financial Relief is a financial assistance program offered by Saint Francis Hospital and Medical Center and The Rehabilitation Hospital of CT for the benefit of our uninsured or underinsured patients who are unable to pay for their care. This policy relates to all medically necessary inpatient, outpatient, clinic, and emergency department visits. **Excluded from this policy are cosmetic procedures, bariatric services, and liability cases.**

SCOPE:

This policy reflects our commitment to individual human dignity with special concern for poor and vulnerable persons.

Application for Financial Relief

1. Application may be obtained from the appropriate hospital personnel: Financial Counselors, Collection Representatives, and Telephone Representatives.

2. The completed and signed application must be returned to the Business Office with the following requested documentation, in the return envelope provided:
   a. Family size - as reflected on prior year tax return; and
   b. Income verification – to include one of the following:
      i. Four most current pay stubs;
      ii. A letter from employer or government agency which verifies income and previous year's tax return; or
      iii. Active Medicaid eligibility screen print that indicates current full Medicaid coverage

   If any of the above required documents are not received the application will be pended for 30 days. A written notification will be sent to the applicant detailing the missing documentation. If not provided within 20 days the application will be denied. An approved application will cover all previous covered services and as well as future qualifying services for the next 6 months.

3. An application for State Medical Assistance (Medicaid) must be completed for those patients with verified income below 100% of the poverty guidelines. If the patient is ineligible for

Medicaid they will be offered hospital financial relief based on the Medicare allowed amounts.

- If a patient is approved for Medicaid with no spenddown, the proof of eligibility determination from the Department of Social Services can be used as verification of their income and be eligible for 100% financial assistance .
- If the balance on an account is the result of a spenddown the income guidelines will apply to determine eligibility. The Medicare allowed calculation will apply so the balance may not be eligible for financial assistance.

Effective 1/1/2014: Un-insured applicants must complete an application through Access Health during open enrollment for eligibility determination for a qualified health plan, or Husky.

4. Eligibility is determined on family size and current income.

   a. Income eligibility is based on the federal poverty guidelines. Patients with income levels **under 200%** of the federal poverty guidelines who are ineligible for State Medical Assistance will receive 100% financial relief.

   b. Patients with income levels between **200% to 250%** of the federal poverty guidelines who are ineligible for State Medical Assistance will be eligible for financial assistance based upon Medicare allowed amount. This may or may not provide a discount on the patient balance that is owed.

Self Pay Patients with income over 250% of the federal poverty guidelines will not be eligible for financial assistance but may still receive a self pay discount if applicable.

Examples:

- **If an insurance payment (cash from insurance) is the same or greater than the Medicare allowed amount for the same service, there will be no patient responsibility. The patient balance will be adjusted 100% with the financial assistance code 97000039.**

- **If the insurance payment is less then the Medicare allowed amount the patient is responsible to pay up to the Medicare allowed. Any amount over the Medicare allowed will be adjusted with the financial assistance code 97000039 or 5017.**

- **Patients with health insurance who have medically necessary inpatient and outpatient services will be eligible to apply for financial assistance in the following instances:**

  - **Reached their maximum benefits**

  - **Entire procedure is non covered due to limitations of their policy or diagnosis**

Patients within the 200-250% of the federal poverty guidelines will be required to pay the Medicare allowed amount.

Patients over 250% of the federal poverty guidelines will be granted the self pay discount.

5. The Self Pay Manager and appropriate personnel determine eligibility within 30 days of receipt of a completed application.

6. Assessment for other free bed funding is completed as part of the financial assessment

ADJUSTMENTS GREATER THAN $5,000.00 ARE SUBJECT TO APPROVALS AS FOLLOWS:

<$4,999 - Customer Service Rep/Financial Counselors/Team Leads
$5,000-$24,999 - Supervisor
$25,000-$49,999 - Manager
$50,000-$99,999 - Director of Patient Financial Services
>$100,000 - VP, Revenue Cycle
After obtaining approval, staff will apply adjustment.

To be Noted

- For all financial relief cases where the patient or spouse is self employed, the gross income will be used after the business expenses are deducted. This information is obtained from the "Profit and Loss Statement" or income reported on the 1040 or 1040A.
- Patients seeking financial relief who are under sponsorship of relatives are determined eligible if the sponsor provides the appropriate income/household documentation. Eligibility is determined on income.
- Cosmetic and Bariatric Procedures are excluded from Financial assistance
- Liability Cases that have secured liens are excluded from Financial Assistance
- Undocumented patients who are eligible for Medicaid Emergency Medical coverage (for their inpatient emergency account) are automatically eligible for financial assistance when proof of eligibility is determined from the Department of Social Services.
- Applications are approved for 6 months.
- Patients with non-contracted insurance carriers or medically necessary non-covered services may be eligible for a discount up to 45 percent on a case by case review (no application required).

CROSS REFERENCES:

Self Pay Billing and AR Management Policy
Emergency Medical Screening and Stabilization/ EMTALA

APPROVED BY: Policy requires Director and Vice President approval.

Director(s): Sarah Alber	Date:	Vice President(s): Nicole Schulz	Date:\
/s/ Sarah Alber	01/30/2015		1/30/2015

REPLACES:

REVISED DATE: 10/1/03; 3/15/04;9/01/04; 11/01/04; 03/07/05; 10/01/05; 10/1/06; 3/1/07; 4/11/08; 5/22/09, 7/1/2011, 1/23/2012 , 7/1/2012, 7/8/2013, 1/15/2014, 4/18/2014; 1/30/2015

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Saint Francis Hospital provides financial assistance to those who qualify based upon household income and family size. However, if your income is under the Federal Poverty Guideline, we would need a denial letter from the State that you reside in or proof that you are already receiving State assistance.

Enclosed you will find an application for financial assistance which needs to be completed and returned along with a copy of 4 (consecutive) paystubs for all household members and a copy of your last filed Federal Tax Return.

Please mail your completed application to:
Saint Francis Hospital
Attn: Patient Accounts
114 Woodland Street
Hartford, CT 06105

If you have additional questions or concerns, please contact a representative for assistance at (860) 714-4952 Monday through Friday between 8:00am - 4:00pm.

Thank you for selecting Saint Francis Hospital and Medical Center for your service.

Sincerely,

Patient Accounts
860-714-4952

SAINT FRANCIS Care Policy	**Title:** **SELF PAY BILLING AND AR COLLECTION POLICY**		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** Business Office	**Number**	**Level** ☐ System ☐ Division ☒ Department
	Category ☒ Administrative ☐ Clinical ☐ HR ☐ EOC	**Published Date** 7/29/2011	**Review Cycle** ☐ 1 year ☒ 3 years

PURPOSE: It is the policy of Saint Francis Hospital & Medical Center that all patients who have received services and that have outstanding financial obligations are given fair and objective opportunities to satisfy these responsibilities. To that end, Saint Francis Hospital commits to the following: Patients/patient guarantors shall receive a summarized bill including but not limited to encounter specific information including dates of service, summarized charges, discounts, payments, adjustments and amounts owed.

- Patients/patient guarantors will be properly informed of the various options available to satisfy their outstanding financial obligation(s) including assistance through the Access Health CT, State of Connecticut's Medicaid Assistance Program as well as through St. Francis Hospital's internal financial assistance program, and recurring payment plan guidelines.
- Patients/patient guarantors will be given an appropriate amount of time (4 statements or 120 days) to respond to such notices of outstanding financial obligations.
- Patients/patient guarantors will be treated with respect and compassion in accordance with the Saint Francis Hospital & Medical Center mission.
- Return mail without other non-identified information is returned, the account may to collections before 120 days.

SCOPE:

This policy applies to the Business office and hospital staff

POLICY:

Self-Pay Billing: Execution of the self-pay billing cycle.

Primary self-pay balances, those balances for which there is no insurance coverage, or self pay balances after insurance has been processed, will receive a series of four statements when the account is released from billing. Self-pay balances resulting from an insurance payment will receive a series of four statements beginning five days from the financial class change to self-pay.

- First, an account is generated and held for the appropriate min days which allows the charges to be associated with the patient encounter. After the min days are satisfied the account is moved from pre-receivable status to active accounts receivable status in the hospital's receivable system.
- Second, a statement displaying a summary of the total charges and the outstanding balance (after any discounts and recent payments have been applied) is generated and mailed to the patient through a contracted agent.
- Simultaneously a file containing the billed inventory is electronically transferred to a contracted self-pay customer service agent to initiate contact and work with patients for account resolution.

Each statement includes a specific message based upon the status and age of the account. The statement cycle can be reset to previously issued datamailer statements through one of two means: Business Office staff can manually reset the dunning cycle or a change in the encounter's financial class. The statement intervals are generated in 30 day intervals and the entire dunning cycle, assuming no interventions, lasts 120 days. All accounts which have an established recurring payment arrangement (payment plan) will receive an alternative self-pay dunning cycle. Payments on payment arrangements must have consistent payment in accordance with the plan. If installment payments are missed the account is eligible for collection.

Self-pay A/R Management: Execution of Self-pay Collection Efforts

Collection efforts on self pay accounts are assigned to a contracted customer service agent from the day the account is ready for billing. The contracted agent receives daily billing files as self-pay claims are generated.

- Follow-up and collection activities will commence upon receipt of the referral.
- Accounts are run through a predictive dialer application/voice broadcasting system to establish initial contact with the patient/patient guarantor. Patients whose established phone number has a voice answering system are left pre-recorded messages indicating the nature of the call and requesting them to contact the St. Francis Billing & Customer Service Department at the appropriate toll-free number.
- All patients shall be made aware of the various financial assistance options available to them including but not limited to assistance through Access Health CT, the State of Connecticut's Medicaid Assistance program, as well as St. Francis' internal financial assistant program and recurring payment plan guidelines.
- All efforts should be made to establish payment plans that resolve an outstanding balance within a reasonable time period. All accounts which have established a recurring payment arrangement in good standing consistent monthly payments for the agreed upon amount are exempt from any bad debt write-off protocols. Should an account become delinquent, a late notice is generated at 15 days a delinquency notice at 30 days past due. If a payment is not received within two months (60 days), a final notice is generated and the account will become eligible for bad debt and written of at the end of the month.

Self-pay Write-offs: Execution of Bad Debt Write-off Protocols

- If a mutually agreed upon recurring arrangement is not establish or if the account is not resolved within the 120 day billing cycle, the account automatically becomes eligible for bad debt write-off. Automatic assignment is changed to reflect bad debt assignment of one of two contracted collection agent.
- A system generated write off report is run and sent to management and each collection agent to review.

Approval of bad debt accounts are as follows:

$5,000-$24,999 - Supervisor

$25,000-$49,999 - Manager

$50,000-$99,999 - Director of Patient Financial Services

>$100,000 - VP, Revenue Cycle

Upon completion of the report review the account is automatically written off to Bad Debt at the end of the month.

- The account balance is subsequently removed from the active accounts receivable and becomes part of the bad debt receivable. Any patient payments secured on this receivable are classified as recoveries to bad debt. Contracted agents will pursue recoveries of referred accounts for a period of 180 days and perform similar referral management and collection activities as described above.
- Any unpaid balance in bad debt with no activity for 180 days, will be returned to the hospital and get referred for secondary placement see **AAB & LEVIN BAD DEBT RETURNS TO EOS CCA PROCEDURE**

REFERENCES:

CROSS REFERENCES: Financial Relief Policy, Emergency Medical Screening and Stabilization/ EMTALA Policy, and AAB & LEVIN Bad Debt returns to EOS CCA procedure.

APPROVED BY: Policy requires Director and Vice President approval.

Director(s): Sarah Alber	Date: 1/30/2015	Vice President(s): Nicole Schulz	Date: 1/30/2015

REPLACES: 3/1/03

Revised Date: 10/1/03; 3/15/04; 9/1/04; 11/01/04; 03/07/05; 10/1/05; 10/01/06; 3/01/07; 4/11/08; 2/21/11; 07/29/2011; 5/22/2013, 2/6/2014; 1/30/2015

SAINT FRANCIS Care Procedure	Title: BAD DEBT WRITE OFF PROCEDURE		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** **DEPARTMENT BUSINESS OFFICE**	**Number**	**Level** ☐ System ☐ Division ☒ Department
	Category ☒ Administrative ☐ Clinical ☐ HR ☐ EOC	**Published Date** July 1, 2011	**Review Cycle** ☐ 1 year ☒ 3 years

PURPOSE:

The purpose of this procedure is to define how to write accounts off to bad debt.

SCOPE:

This procedure applies to the Business Office-Patient Accounting Department.

PROCEDURE:

A. BAD DEBT WRITE OFF PROTOCOL:

All Self Pay accounts shall be given a 45% discount off of billed charges effective 1/1/12. This discount was applied at the time of initial billing. Exclusions are cosmetic procedures, bariatric services, and liability cases.

Account balances which have not been resolved after a series of 4 patient statements during the dunning cycle which is 120 day assuming no interruptions, automatically becomes eligible for bad debt write-off.

- Exclusions to this protocol are: Mail Returns, Small Balance Write off, Unresolved patient disputes or billing issues, and Bankruptcy discharges. Which may result in early placement to bad debt or early discharge of an account.

The financial class assignment is automatically changed to reflect the corresponding assignment of the bad debt to one of two contracted collection agents. Effective 11/1/2011: Claim inventory is split alphabetically with patient last names beginning with the letters A – MI being assigned to American Adjustment Bureau staff (financial class code 951 - American Adj Bur BD, financial class code 953 - BD Mcare SP - AAB) and the remainder of the alphabet MJ - Z being assigned to Nair & Levin staff (financial class code 920 - Nair & Levin BD, financial class code 972 - BD Mcare SP - N&L). Liability accounts assigned to the Outsource Group or TCORS will get written off to bad debt if the case is not resolved within the 120 day dunning cycle.

- A report of accounts eligible for bad debt greater than $5,000 is generated and distributed to the Self Pay Manager, Director and Vice President.

ADJUSTMENTS GREATER THAN $5,000.00 ARE SUBJECT TO APPROVALS AS FOLLOWS:

$5,000-$24,999 - Supervisor
$25,000-$49,999 - Manager
$50,000-$99,999 - Director of Patient Financial Services
>$100,000 - VP, Revenue Cycle

The account balance is subsequently removed from the active accounts receivable and at month end, the system will automatically write off accounts in these financial classes which becomes part of the bad debt receivable. Any patient payments secured on this receivable are classified as recoveries to bad debt.

Contracted agents will pursue recoveries of referred accounts for a period of 180 days and perform similar referral management and collection activities as described above. Upon culmination of the 180 day holding period, any unpaid balances will be returned to the hospital.

Accounts that are returned as uncollectible may be considered for secondary placement with a contracted collection agency EOS CCA. The appropriate returned transaction code is applied to the account and the financial class is changed to 931 EOS CCA bad debt 932 EOS CCA Med Bad Debt. An electronic inventory is sent to the collection agency to pursue accounts for an additional 180 days. Any unpaid balances will be returned to the hospital.

B. Write Off/Account manually:

Epic: Activity Code 294 Manually send to Bad Debt

SFS: Accounts that need to be written off manually to an outside Collection Agencies can be flagged for write off by simply changing the Financial Class or Status of the account to the agency.

- Other agencies should be written off in the following manner:
  1) Change the Financial Class to the Agency
  2) SFS Pathway is: PA, PM, AR, WO - In the write off service code enter 97111111
     In the balance forward service code enter 97970000
     Answer Yes to the write off question.
- Example:

Name: KOLE SUSAN	VT: I	Acct: 100000095	Acct. Bal: 1300.00
AR Per: Entire Account	AS: A	FC: SAGA/CITY(REVENU	Per Bal: 1300.00

Write-Off Service Code: 97111111 BAD DEBT MOVE
Balance Forward Service Code: 97970000 SFS BAD DEBT WRITE O

Write-Off This Account? YES

This account will now be in Bad Debt status. The account balance will still show, but is in the Bad Debt receivable.

C. REACTIVATING A BAD DEBT ACCOUNT:

EPIC: Activity 526 SFH Return from Bad Debt

SFS: The write off reactive function in the PM menu should be used to bring the account back from bad debt. PA/PM/AR/WO. The codes to use are 972222222 AR Move in the reactivate the account and 97970000 as the Balance forward code.

- Example:

  Name: ABERNATHY DENISE VT: C Acct: 50230028799 Acct Bal: 135.31
  AR Per: Entire Account AS: B FC: ELIG MEDICAID AUT Per Bal: 135.31

SFS:

Re- Activate Service Code: 97222222 AR MOVE
Balance Forward Service Code: 97970000 SFS BAD DEBT WRITE O

Re-Activate This Account? YES

EPIC: Activity Return from Bad Debt

C. WRITING ACCOUNTS OFF TO ZERO BALANCE:

- The write off to Bad Debt is only intended for accounts that are being followed up by agencies. Accounts being written off for other reasons (i.e. Denied timely filing, bankruptcy, etc.) should be done through transaction entry. PA, PM, FIN, TE.
- The following adjustment codes should be used:

SFS	EPIC	
⇒ 97000011 -	128	Bad Debt Wo
⇒ 97000023 -	5015	Small Balance
⇒ 97000026 -	5003	Bankruptcy
⇒ 97100085 -	5063	Medicare
⇒ 97000610 -	5051	Denied Timely Filing

These accounts will not turn to bad debt status, but will go to zero balance.

D. INTERRUPTION OF DEBT COLLECTION PROCESS

- All outside collection agencies will be providing a copy of the hospital free bed/financial assistance summary in all communication to a patient. (i.e. hospital one page summary sheet).
- At any time during the collection process, if the collection agency has determined that the patient may qualify for a free bed fund or financial assistance, the account will be referred back to the hospital. At this time all outside collection activity will stop until financial assessment is completed.

E. Second Placements

- The Hospital reserves the right to send accounts that have been closed by the primary collection agency to a secondary agency for further collection efforts. The above process will remain the same for secondary placements.

REFERENCES:

CROSS REFERENCES:

APPROVED BY: Policy requires Director approval.

Director(s): Sarah Alber	Date:
/s/ Sarah Alber	1/30/2015

REPLACES:
January 23, 2009 procedure

REVISED DATE: 3/21/12; 5/22/13; 1/15/2014; 4/18/2014; 1/30/2015