C-tag: 1.1

References: Definitions attached

Rept #15
Docket # 15-029AR

JOHNSON MEMORIAL MEDICAL CENTER

PATIENT ACCOUNTS DEPARTMENT

CREDIT AND COLLECTION POLICY

I. POLICY:

It is the policy of the Hospital to maintain a viable business operation in order to facilitate and support, on a continuing basis, the rendering of high quality health care through prudent financial operations.

It is the policy that the Hospital will coordinate the admitting, patient billing, and insurance billing procedures they use to obtain the financial information needed to process the billing and collect the charges incurred by patients during delivery of health care.

It is policy that these procedures interrelate in a manner consistent with efficient management practices, in order to receive reimbursement of all Hospital charges on a timely basis.

The patient or the party responsible for payment that may experience difficulty in repaying will receive individual attention as to obtaining benefits, a mutually acceptable repayment schedule, or uncompensated medical services under available outside assistance on the Hospital's Financial Assistance Program. Payment for services rendered will be pursued through all avenues in order to minimize the expense of bad debts to the organization.

II. APPLIES TO:

Patient Accounts Staff

III. PROCEDURE:

1. ACQUISITION OF FINANCIAL INFORMATION
   A. The hospital shall have in place appropriate procedures to ensure the collection of sufficient information in order to assess the ability of the patient or the patient guarantor to pay for Hospital services. The patient-supplied information shall include, but shall not be limited to, the patient's name and address and employer name and address, the guarantor's (if different) name and address and employer name and address, and the source of any available third party payments.
   B. The Hospital shall make reasonable effort to secure this information in the following manner:

C-tag: 1.1

References: Definitions attached

i. Inpatients
ii. Prior to Admission
    a. Telephone contact with all elective admissions
iii. Date of Admissions
    a. Interview process with all admissions.
iv. During Hospital Stay
    a. In coordination with clinical approval, patient will be interviewed on floor, or if available, guarantor or family member will be contacted to supply information.
v. At Discharge
    a. Hospital personnel will review checklist of needed data to ensure completeness prior to the patient leaving the Hospital.
vi. Post Discharge
    a. The Hospital will contact the patient and/or guarantor by telephone or letter if necessary.
vii. Outpatient Services
viii. Prior to Services
    a. Where sufficient advance scheduling occurs, telephone contact will be attempted.
ix. Date of Services
    a. Interview process with all patients prior to their receiving services, or in the case of severe emergency room treatment, post service being rendered.
x. Post Services
    a. Contact with patient/guarantor by telephone or letter as appropriate.

2. VERIFICATION OF FINANCIAL INFORMATION
   A. The Hospital shall make reasonable effort to verify all information supplied by the patient/guarantor. This shall include but not be limited to, copying of all insurance cards, copying of automobile license, telephoning of employer and/or insurance carrier to determine coverage, and review or prior Hospital records for veracity of past information.

3. ASSISTING PATIENTS WITH LIMITED FINANCIAL RESOURCES
   A. If, during the admission/registration or verification process outlined in sections 1 to 2, it is determined that there may be an inability of a patient to meet his/her financial obligation to the Hospital due to their coverage limitations and/or economic situation, the Hospital will provide an array of assistance programs to meet the needs of both the patient and the Hospital.

      Public Act No. 03-266
      When a patient has been identified as uninsured, as defined by the Looney Law SB568, they shall only be responsible for the cost of the services provided. This is calculated by total gross charges and multiplied by the Ratio of Cost to Charge.

      I. DEPOSIT PLAN: In the absence of any insurance coverage, and an apparent ability to pay, a deposit of at least 25% of the expected total amount due may be requested prior to the service being rendered for all elective patients. The Hospital will not require

C-tag: 1.1

References: Definitions attached

preadmission/pretreatment deposits of patients who require emergency services.

ii. PAYMENT PLANS: The Hospital, at its option may offer an interest free payment plan predicated upon the following guidelines:
   a. Balances of $1,000 or under-up to twelve (12) months.
   b. Balances over $1,000 and higher-up to twenty-four (24) months.

iii. DEFERRED TREATMENT: In extreme situations with a patient who has been determined to have sufficient financial resources and where an appropriate agreement and/or accommodation cannot be obtained, in concert with the appropriate clinical approval, the Hospital may deem it necessary to defer elective treatment due to financial considerations. This decision requires the approval of the Adm. Dir., Business Operations, the V.P., Finance and V.P., Medical Affairs.

iv. TITLE XIX (MEDICAID): State administered funding for those who have income within the Title 19 guidelines and are either age 65, blind, disabled, a family with dependent children or individuals under the age of 21.

v. SOLDIERS. SAILORS AND MARINES: Assistance for those individuals who served at least 90 days unless separated from the service earlier because of a service connected disability and served in the active military or naval forces of the United States or forces allied with the United States between designated war time periods. Applicants must be honorably discharged or separated from active military service, meeting income and asset guidelines set by the Soldiers, Sailors & Marines Fund. Spouses and other dependents may also be eligible for these benefits.

vi. VETERANS ADMINISTRATION: Individuals must have served in the armed forces at some time or have a service related disability and have served in the armed forces during war time. Veterans with non-service related disabilities may qualify for benefits if they meet certain eligibility requirements.

vii. BRAINARD FUND: Private funding administered through the Hartford Foundation for Public Giving for those individuals whose medical bills are not covered under medical insurance or other third party payer. Individuals must not be eligible for public assistance or likely to become eligible for public assistance in the near future. Recipients must be self-supporting whose financial hardship is caused substantially by their illness. Eligibility determination may involve a review of income, assets, monthly expenses and outstanding debts.

viii. HEALTH FUND

4. COLLECTION EFFORTS

A. BILLING

I. Final detail bills and insurance claim forms (UB-04, 1500, etc.) are produced, at a minimum, four (4) days after discharge (inpatient), date of service (outpatient) or completion of Medical Records coding. After review for completeness and correctness, the insurance claim is submitted to the appropriate third party either through electronic claim submission or hard copy submission. In the absence of third party coverage, a statement is sent directly to the patient or guarantor.

C-tag: 1.1

References: Definitions attached

ii. Secondary coverage claims are submitted to the appropriate third party once the primary carrier has completed its adjudication of the claim.

B. STATEMENTS
   i. Formalized written collection efforts commence with Cycle Billing. Four statements are sent within a minimum of 120 days.

C. TELEPHONE FOLLOW-UP
   i. A self-pay account over $100 is contacted by telephone (provided appropriate level of staffing is available.)
   ii. All bills are reviewed on CRT initially. If insurance coverage is indicated, the billing process is reviewed to assure payment and proper posting of the same.
   iii. Where less than 100% insurance coverage is indicated, balances are transferred into self-pay and cycle billing begins.
   iv. When there is no indication of insurance, the pay class must be self-pay and the patient must be called.
   v. Prior to the initial telephone call, each file memorandum is reviewed for the last action taken by Patient Account Representative and to determine whether the patient or his/her insurance carrier should be contacted. All *efforts* are properly recorded to assure timely follow-up and documentation for third party audits.
   vi. The first call is the most important one. All relevant facts are covered, i.e., the current balance and how the account will be paid. The conversation must always end with a firm commitment from the patient. This should be either a promise to pay, a promise to call back, or an appointment to discuss the situation in person.
   vii. All patients are called at their residence whenever possible. Calling patients at their place of business is a last resort and occurs only after two attempts to the home are made.
   viii. Any patients who cannot be reached by phone at home or work is sent a collection letter (see Appendix "A") generated by the Collection Department. No response within ten (10) days will result in the account being turned over to outside collection or attorney after write-off procedure is followed.

D. CONTRACT ACCOUNTS
   i. Objective - to establish a reasonable payment schedule in consideration of the balance due to the guarantor's ability to pay through a financial evaluation process using the general payment parameter guidelines as indicated in the credit collection policy manual.
      a. The initiation of a payment schedule may be made by the patient or by a collector during the normal collections process.
      b. Upon establishing a payment schedule, which may include an initial down payment, a contract agreement in duplicate is signed by the guarantor and returned to the credit office, prior to or in conjunction with receipt of initial contract payment (refer to policy 1.7 Payment Plan Contract Policy). A copy of the contract agreement is retained by the guarantor for his or her records, referencing the monthly payment due and account number to be used to insure proper posting of payments.
      c. Upon receipt of a signed contract the account is changed to contract status within the data system, reflecting date of first or

C-tag: 1.1

References: Definitions attached

next payment and amount due on a monthly basis. Month end billing references balance due and current or delinquent statuses are applicable.

d. Delinquents' contracts of two months or more in arrears are monitored by the credit offices to determine further collection efforts or referral to an outside collection agency.

E. SETTLEMENTS

I. Based on individual circumstances and in the absence of third party coverage, and/or absence of eligibility for full-uncompensated care, settlements can be arranged whereby the patient is not responsible for the full balance, providing they pay a lump sum that will be agreed upon as total settlement for the account. An acceptance of Settlement From must be completed (see Appendix "C"). All pertinent financial information is discussed to develop an accurate picture of income versus expenses. Pay stubs and other income verification statements are requested. Savings and other assets which might be a source of settlement are also researched. When a lump sum settlement appears justified, the following guideline is used:

a. Balances of $350.00 or less — Balance is full.
b. Balances of $351.00-$700.00 — 85%
c. Balances of $700.00-$1,000.00 — 80%
d. Balances of $1,001.00-$2,000.00 — 75%
e. Balances of $2,001.00 + over — 70%

F. REFERRING ACCOUNTS TO AN ATTORNEY OR COLLECTION AGENCY

I. The final step in the Hospital collection efforts is turnover to attorneys or outside agencies. This occurs only after third party monies are properly posted, the patient had been billed and/or called, and:

a. Patient or Guarantor refuses to pay.
b. Patient or Guarantor had made no attempt to fulfill his/her obligation to the Hospital.
c. Determination as to whether the patient is uninsured as defined by Public Act No 03-266.

II. All inpatient and outpatient accounts for which the Hospital receives return mail are first researched. If the patient or guarantor cannot be located, these accounts are immediately referred for outside collection or determined to be uncompensated care (see section 5 Bad Debt Assignment).

III. All other accounts are both system flagged and noted on weekly credit reports. Along with those accounts selected from individual financial classes, receivable reports are reviewed individually by the Collection staff to determine their collectibles. Those patients with self-pay balances and apparent ability to pay who are unresponsive to JMH collection efforts are routinely turned over to outside collection, with final approval being the responsibility of the Director of Patient Accounts.

iv. Occasionally a payment is received shortly after an account is turned over. Unless there are extenuating circumstances (Doctor's or Administrative request, Insurance Payments, etc.), the Hospital will not recall the account. Also, as part of the regular procedure, the collection agencies will be notified when payments are received.

C-tag: 1.1

References: Definitions attached

v. Exception to turnover:
   a. are balances under $20.00. These balances are written off if there is no response to the past due notices and inquiries by the Credit Department;
   b. active Johnson Memorial Hospital employees will given an opportunity to pay balances through reasonable payroll deductions prior to turnover.

5. BAD DEBT ASSIGNMENT
   A. ROI prepares a listing of both inpatient and outpatient accounts that are being recommended for write-off. The electronic file if received and reviewed by Patient Accounts staff and approved or denied for submission to the bad debt agency.
   B. Balances resulting from Medicare deductibles and/or Co-insurance amounts, excluding physician compensation, which have gone through the normal collection effort, will be assigned to a Collection Agency as other accounts prior to being claimed as a Medicare Bad Debt. This will assure proper acknowledgement and payment under the Medicare Bad Debt policy and procedure

Date of Origination:
07/09/1994

Signature

04/03/07; 12/27/11; 10/17/12
Revision Dates

C-tag: 1.1

References: Definitions attached

DEFINITIONS

Bad Debt — An account receivable based on services furnished to any patient which:
1. Is regarded as uncollectible, following reasonable collection efforts, pursuant to the Hospital's credit collection policies and procedures,
2. Is charged as a credit loss pursuant to the Hospital's credit and collection policies and procedures,
3. Is not the obligation of any unit of the federal and/or state government or agency thereof, and
4. Is not uncompensated care.

Brainard Fund — A privately endowed fund which periodically makes available monies to assist eligible applicants whose payment of their medical expenses could cause a severe financial burden.

Charge — The amount to be billed or charged by Hospital for each specific service within a revenue center.

Collection Action — Any activity by which Hospital or it's designated agent requests payment for services from a patient or a patient's guarantor. A collection action of Hospital shall include those activities such as pre-admission or pretreatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts and activities of collection agencies and attorneys.

Commission — Commission on Hospitals & Health Care (CHHC).

Credit and Collection Policy — The Hospital's policy, as expressed in a statement of general principles approved by its governing board, guiding the management of Hospital's billing and collection of accounts receivable, and the Hospital's procedures, with respect to:
1. the effort the Hospital makes to collect payment for services,
2. the criteria the Hospital uses to assign uncollectible accounts to bad debt and free care accounts, and
3. the criteria the Hospital uses for the provision of uncompensated care.

Elective Admission — A scheduled admission for the purposes of providing medically necessary services on an inpatient basis.

Elective Services — Medical, surgical or other health services which the treating physician determines are required are not life threatening, but need to be accomplished as soon as it is reasonable to schedule them.

Emergency Admission — An unscheduled admission through the Hospital's emergency room for the purpose of providing medically necessary serviced on an inpatient basis.

C-tag: 1.1

References: Definitions attached

Emergency Services Medical, surgical or other health services which are required to be provided immediately due to the unexpected or sudden onset of an illness, injury or condition to avoid damage to the individual's health status

Federal Poverty Income Guidelines
(F.P.I.G.) The federal poverty income guideline used as an eligibility criterion by the federal Department of Health and Human Services.

Guarantor A person or group of persons who assume(s) the responsibility for payment of (all or part of) the Hospital charges for services, but not including third party payers.

Medical Hardship A situation in which major expenditures for health care and/or income loss stemming from an individual's medical condition have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that he or she will be unable to pay for needed medical services.

Medically Necessary Service
A service that is reasonable calculated to prevent, diagnose, alleviate, correct, or cure conditions in the recipient that endanger life, cause mental or physical suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity.

Medicare Bad Debt Deductible and Co-Insurance amounts, excluding physician compensation owed by Title XVIII (Medicare) eligible patients, which are unpaid due to their financial situation and are generally reimbursed directly by the Federal Government.

Patient An individual seeking services at, or who has already been admitted to a hospital.

Uncompensated Care Pool
As per Section 17, Public Act 91-2, a grant used for financial assistance to low-income patients who have no insurance and whose family income level is below twice the national poverty level.

Uncompensated Care
Unpaid hospital charges of medically necessary services to patients who have been deemed, pursuant to the Hospital's Credit and Collection policy, financially unable to pay for all or part of the Hospital care rendered to the patient. This may include patients who Title XIX pending status is changed to denied status yet meet the charity care guidelines.

Urgent Admission An unscheduled admission directly from home, nursing home, or physician's office.

C-tag: 1.2

JOHNSON MEMORIAL MEDICAL CENTER

PATIENT ACCOUNTS DEPARTMENT

COLLECTION PROCESS FOR SELF PAY ACCOUNTS POLICY

I. POLICY:

It is the policy of the Patient Accounts Department to work with all patients/ guarantors to resolve in a reasonable and timely manner any balances owed to the Hospital.

II. APPLIES TO:

Patient Accounts Staff

III. PROCEDURE:

1. All self-pay accounts will receive a series of four statements, 30 days apart in an attempt to collect on an outstanding debt. Thirty days after the third statement, if no payment and/or communication are received from the patient, the patient is sent a final notice to collect prior to turn-over to an outside collection agency/attorney for collection. Thirty days after submission of the final notice, if there is no payment and/or communication from the patient, the account is then turned over to an outside agency for collection.

2. A self-pay account is any account in-which the patient is responsible for the outstanding balance. This may represent accounts with balances after a third party has paid and/or accounts with no third party payer.

3. Once an account is turned-over to an outside agency, the account is theirs to work.
    a. All patient communication must be referred to the agency.
    b. All notifications for bankruptcy and/or requests for settlement should be forwarded to the agency.
    c. Any changes made to an account which would impact the patient liability needs to be communicated to the agency.
    d. All payments and adjustments made to accounts in Bad Debt are reported to the agency weekly.
    e. Establishing a payment plan after the account has gone to Bad Debt is not reason to recall the account. The patient must be referred to the agency to establish the payment plan.

4. Once the agency has accepted our accounts and commenced working them, any accounts to be recalled from an agency must have management approval.
    a. To recall an account from the agency, notification MUST be made to the agency via fax or e-mail. Notification may also be made via telephone, however, a fax or e-mail provides us with better record of the recall.

b. Once notification is made, a comment must be put on the patient's account and the account status changed to appropriately reflect the recall.

5. If we receive payment or confirmation of coverage via third party on an account that has been turned over to an agency within ten (10) days from turnover, we can recall the account from the agency. We will also recall accounts that have been sent in error regardless of time with agency. All other request will require management approval.

6. While the account is in Bad Debt, we have the ability to bill a third party without removing the account from Bad Debt. These accounts are still considered to be with the bad debt agency

Date of Origination:
10/08/2007

Signature

10/01/09; 12/29/11; 10/17/12
Revision Dates

C-tag: 1.3

JOHNSON MEMORIAL MEDICAL CENTER

PATIENT ACCOUNTS DEPARTMENT

BAD DEBT POLICY

I. POLICY:

To capture all of the self pay accounts that qualify for bad debt and process them to the proper agencies. Accounts that are approved for bad debt assigned to American Adjustment Bureau. Accounts are assigned once they have been in a self pay status for a minimum of 120 days with no payment received.

II. APPLIES TO:

Patient Accounts Staff; Patients

III. PROCEDURE:

1. ROI sends the files via email on Tues or Wed. There are 2 reports in the email called "ROI return for bad debt" and ROI non collectible returns. Save to the J drive and there is a folder for each report. Print the reports.
   A. Click Agency processing (to assign the agency) which is done using the reports from ROI. Input today's date in the top left. Choose American (do not choose the one that says Medicare in the name)
   B. Click Batch Agency assign (on the bottom right) click assign.
   C. On the top right of the screen, single click the agency you want (American, not the one with Medicare in the name)
   D. Next on the top left of the screen. Enter all the accounts.
   E. Click update and Print

2. Go back to the main screen in patient management.
   A. Click on patient maintenance. Enter the account number. Click the billing tab.
   B. Click bad debt write off request
   C. Choose the agency. (American, not the one with Medicare in the name)
   D. Click assign (enter each account individually to assign)

3. Go back to the main screen in patient management
   A. Click write off processing icon
   B. Click bad debt write off
   C. Click preliminary (don't print)
   D. Click post write offs (don't print)
   E. Close (only a small list is left) close

4. Go back to the main screen
   A. Click Agency processing
   B. Click today's date
   C. Choose both Americans
   D. Under Agency data transfer, click transfer
   E. Click create file

C-tag: 1.3

F. Change all the "c" to "f" then add aab and the date to the filename
G. Click create, then close.

5. On the next day the Web Report has to be run. This icon is only available on the IT Billing department computers

Date of Origination:
12/27/2011

Signature

10/17/12
Revision Dates

C-tag: 1.4.1

JOHNSON MEMORIAL MEDICAL CENTER

PATIENT ACCOUNTS DEPARTMENT

DEPARTMENT OF SOCIAL SERVICES (DSS) APPLICATION POLICY

I. POLICY:

To identify all self-pay patient admissions that may qualify for State medical assistance applying through the Department of Social Services (DSS). All patients admitted as self-pay may complete a DSS application form and must provide proof of information declared in the DSS application form.

II. APPLIES TO:

Patient Accounts Staff; Patients

III. PROCEDURE:

1. As an additional service to patients, Johnson Memorial Hospital (JMH) offers assistance in applying for State and Federal programs that may help pay medical bills for uninsured or underinsured patients. This assistance is provided by the Entitlement Specialist and/or by the Patient Accounting Customer Service Representative.

2. The entitlement specialist and/or customer service representative will be notified of a self-pay admission immediately or shortly after identification of lack of medical insurance as follows:
    a. Contact entitlement specialist Maria L. Palomares by calling x8193 or by e-mailing Maria.Palomares@jmmc.com
    b. Contact customer service representative Barbara Hicking by calling x8553 or e-mailing Barbara.Hicking@jmmc.com
    c. Provide patient's name and contact information.
    d. If in-patient provide name and unit where patient is located.
    e. Entitlement specialist and/or customer service specialist will contact patient to go over DSS application process.

3. If in-patient, contact will take place as follows:
    a. Entitlement specialist and/or customer service speCialist will call the unit where patient is receiving care to make sure it is appropriate to go visit and talk to patient.
    b. When OK to visit patient announce your visit to the nurse station.
    c. Enter patient's room, introduce yourself and explain the reason for the visit. Bring with you a DSS packet.
    d. If patient agrees to start the completion of DSS application form ask as many questions as possible. Keep in mind that patients may get tired or aggravated easily while sick so be aware for any signs of distress.
    e. If unable to complete or answer all questions, offer to come back at another time or leave the DSS application for patient and/or family member to finish.

Tell patient and/or family member about the contents of the DSS packet. Explain patient he/she will be required to provide proof of information declared in the DSS application form.

f. Collect completed application and proof of information when ready. Inform patient that all documents will be faxed to the DSS office and he/she will receive a letter from DSS requesting more documentation or indicating whether he/she was approved to receive State medical assistance.
g. Patient must contact DSS for any further inquiries regarding DSS application, programs or services.

Note: Each interaction with patient must be documented on Paragon's patient account.

4. If out-patient, contact will take place as follows:
   a. Entitlement specialist and/or customer service specialist will mail patient a DSS packet along with contact information letter.
   b. Patient will be contacted within 7 working days from mailing the above material.
   c. If patient available to talk offer him/her to set up a meeting to complete the DSS application form or ask the questions over the phone. Remind patient to bring proof of information declared in the application to make copies and fax all documents to the DSS office.
   d. If patient is unresponsive after 3 follow up attempts send final letter with a payment plan form.

Note: Each interaction with patient must be documented on Paragon's patient account.

Date of Origination:
09/2011

Signature

12/28/11; 10/17/12
Revision Dates

C-tag: 1.4.2

JOHNSON MEMORIAL MEDICAL CENTER

PATIENT ACCOUNTS DEPARTMENT

DEPARTMENT OF SOCIAL SERVICES (DSS) ELIGIBILITY VERIFICATION PROCESS POLICY

I. POLICY:

To verify State insurance status when registering a self-pay patient. Self-pay patients may not know they have active State medical assistance coverage or spenddown benefit. JMH should verify insurance eligibility when registering every patient that seeks medical attention.

II. APPLIES TO:

Registrars

III. PROCEDURE:

1. Open Windows Internet Explorer
2. Enter the following we address into the address area:
   a. https://www.ctdssmap.com/CTPortal/Provider/Secure%20Site/tabId/53Default.aspx
3. Login by entering your user ID and password and click on the login button.
4. These are provided by the Patient Accounting department manager.
5. Under the "Quick Link" area located in the box on the right of the screen, click on Client Eligibility Verification link.
6. Enter any of the combinations listed under Valid Search Combinations area and click on the search button.
7. Eligibility Verification Response will appear on the bottom of the page.

Date of Origination:
09/2011

Signature

12/28/11, 10/17/12
Revision Dates

C-tag: 1.4.3

JOHNSON MEMORIAL MEDICAL CENTER

PATIENT ACCOUNTS DEPARTMENT

FINANCIAL ASSISTANCE APPLICATION POLICY

I. POLICY:

Johnson Memorial Hospital (JMH) recognizes that there are times when patients in need of medical care will have difficulty paying for services provided. JMH's financial assistance program may provide discounts to qualifying individuals based on their income and assets.

II. APPLIES TO:

Patient Accounting Department, Customer Service Representative

III. PROCEDURE:

1. Applications for financial assistance are available upon request. Eligibility is based on the 2014 U.S. Department of Health and Human Services Income Guidelines as shown below:

2015 FINANCIAL ASSISTANCE GUIDELINES

Free Care Standard Size of Family	Federal Poverty Level 100% Assistance Maximum	200% Poverty Federal Poverty Level 100% Assistance Maximum	250% Poverty Federal Poverty Level 75% Assistance Maximum	300% Poverty Federal Poverty Level 50% Assistance Maximum	400% Poverty Federal Poverty Level 25% Assistance Maximum
1	$11,770.	$23,540	$29,425	$35,310	$47,080
2	$15,930	$31,860	$39,825	$47,790	$63,720
3	$20,090	$40,180	$50,225	$60,270	$80,360
4	$24,250	$48,500	$60,625	$72,750	$97,000
5	$28,410	$56,820	$71,025	$85,230	$113,640
6	$32,570	$65,140	$81,425	$97,710	$130,280
7	$36,730	$73,460	$91,825	$110,190	$146,920
8	$40,890	$81,780	$102,225	$122,670	$163,560
For each additional person, add	$4,160	$8,320	$10,400	$12,480	$16,640

2. Financial assistance is available for patients with limited incomes and no health insurance or underinsured. Underinsured patients are those who have a

deductible or combined outstanding balances of at least $500.00 regardless of the type of insurance including State insurance spend-down benefit.

3. All persons unable to payor unable to pay in full for hospital services, may apply for Financial Assistance but must be US citizens of legal aliens. In addition, all self-pay patients may receive a 25% discount from charges if paid within 30-days of initial billing.

4. When requested by a patient, the customer service representative will mail a . Financial Assistance Application (FAA).

5. The FAA will be mailed back to JMH with all the required documentation including but not limited to:
    a. Copy of determination letter from the Department of Social Services (DSS) **(mandatory,** exception: DSS letter will not be necessary if it is determined that applicant will not qualify for State medical assistance or if the bill is more than 3 months old.
    b. **Four** recent employer pay stubs for patient and any dependents or four recent unemployment stubs.
    c. Copy of previous year's 1040-tax form. If requesting financial assistance between the months of January to April the 1040-tax form from 2 years prior may be accepted if no taxes have been filed from previous year.
    d. Proof of alimony, child support, and/or divorce decree.
    e. Proof of estate, dividends, allotments, tips, social security, retirement pension slips, workers compensation or strike benefits, net winning income, royalties, annuity income, welfare benefits or general assistance benefits.
    f. If self-employed, receipts from unincorporated business, professional enterprise, or partnership after deductions for business expenses. If requesting financial assistance between the months of January to April the 1040-tax form from 2 years prior may be accepted if no taxes have been filed from previous year. Also include schedule K-l (1120).
    g. If the hospital charges occurred under part or third party liability suit, please disclose this information.
    h. If none of the above proof-of-income applies, please provide a detailed letter explaining the means of support for you, your family or household unit.

6. Written determination will be made within 30 days after submission of a completed application.

Date of Origination:
09/2011

_____
Signature

12/28/11, 10/17/12, 02/01/15
Revision Dates

C-tag: 1.7

References: Payment Plan Contract (attached)

JOHNSON MEMORIAL MEDICAL CENTER

PATIENT ACCOUNTS DEPARTMENT

PAYMENT PLAN CONTRACT POLICY

I. POLICY:

To insure the patient/guarantor is fully aware of their responsibility in the resolution of their unpaid account. To properly communicate to the patient/guarantor the expected amount of payment and recourse if plan is not followed. To require all patients/guarantors to acknowledge the requirement of an approved payment plan by signing a payment contract.

II. APPLIES TO:

Patient Accounts Department

III. PROCEDURE:

1. All requests for a payment plan arrangement will be forwarded to the Customer Service Representatives.

2. Patients will be informed of our policy to approve a payment plan only if the patient can demonstrate a financial hardship.

3. If no financial hardship the patient will be expected to seek financial assistance from other sources such as: Banks, Credit Union, Financial Institutions, Credit Cards, etc.

4. A Financial Assistance application will be sent to the patient to complete and return with supporting documentation.

5. Customer Service will review all applications and submit to Management with recommendations.

6. Except in unusual circumstances, payment plans will be approved based on guidelines outlined in the Credit and Collection Policy.

Balance	Payment Plan
Under $100	Payment in full
$100 to $1,000	Up to twelve (12) months (minimum of 1/12 of the balance due each month)
$1,001 and over	Up to twenty four (24) months (minimum of 1/24 of the balance due each month)

C-tag: 1.7

References: Payment Plan Contract (attached)

7. Once a plan is agreed to, a payment contract will be completed. The payment contract will identify:
    a. Total outstanding balance.
    b. The $ dollar amount of each monthly payment..
    c. The date the first payment is due.
    d. The number of payments to be made.
    e. Patients' responsibility for any collection fees, interest and court costs if they default on payment.

8. The Payment Plan Contract must be signed by the patient/guarantor and witness.

9. Once the contract is signed and witnessed, the account will be set up as a contract account and outside S/P vendor will be notified.

10. A completed payment plan contract will be scanned into HPF.

11. A comment on the patient's account will also be entered.

Date of Origination:
10/10/2007

John Gesk
Signature

12/27/11, 10/17/12
Revision Dates

C-tag: 1.7

References: Payment Plan Contract (attached)

JOHNSON MEMORIAL MEDICAL CENTER
PATIENT ACCOUNTS DEPARTMENT
PAYMENT PLAN CONTRACT

PAYMENT PLAN / CONTRACT

NAME: Mr. / Mrs. / Ms. _____

ADDRESS: _____

_____

_____

SS #: _____

ACCOUNT # _____ **OUTSTANDING BALANCE:** _____

I agree to make monthly / weekly payments in the amount of $_____ for a period not to exceed _____ months / weeks. I will make my first payment on _____.

In the event that at any point I am unable to meet the terms above referenced and the unpaid balance is referred for collection, I will also be responsible for the interest at the legal rate, reasonable attorney fees and any other costs associated with the collection of the delinquent balance.

I have read the above terms and agree to them of my own free will.

Signed: _____ Date: _____

Witness: _____

DATE

NAME
STREET ADDRESS
CITY, TOWN, ZIP

DEAR PT NAME

The following Financial Evaluation has been completed on the Information you have provided. You have been awarded % FinFinancial Aid.

Account #	Date of Service	Balance before Award	Balance after Award
			$0.00

In addition, please feel free to contact your Customer Service Representative with any questions that you might have concerning your Financial Assistance adjustment.

Sincerely,

Barbara H.
Pt. Account Representative
860-684-8553

DATE

NAME
ADDRESS
CITY, STATE ZIP

Dear.

Enclosed, please find a financial assistance application. Upon receipt, please complete and return the application **within 30 days** for financial assistance consideration. **Please pay close attention to the information requested**. If we do not receive all necessary information within this time frame, your application may be denied. If you have any questions, please feel free to contact me at **(860) 684-8553**, I am available Monday through Friday, 8:15 a.m. until 4:15 p.m.

Sincerely,

Barbara H.

Customer Service Representative
Patient Accounting Dept.
Johnson Memorial Hospital
201 Chestnut Hill Rd
Stafford Springs CT 06076-4005

jmmc
Johnson Memorial Medical Center
Health care. The way it should be.

Financial Assistance Application

Date Completed: _____

First Name: _____ Last Name: _____

Street Address: _____ Apt No.: _____ PO Box: _____

City/Town: _____ State: _____ Zip Code: _____

Phone #: _____

Number of Dependents (including spouse) in household: _____
Total Dependents under 18 years old: _____

Income verification is required for all applicants in adherence to the JMH program guidelines listed below. In order for your financial assistance application to be processed, you must provide copies of the following documents as applicable to your 2012 income:

- Copy of determination letter from Department of Social Services (**mandatory**).
- **Four** recent employer pay stubs for yourself and any dependents. Please indicate periods of unemployment.
- Copy of **most recently filed** 1040-tax form (**2010** or **2011**).
- Proof of alimony, child support, and/or divorce decree.
- Proof of estate, dividends, allotments, tips, social security, retirement pension slips, workers compensation or strike benefits, net winning income, royalties, annuity income, welfare benefits or general assistance benefits.
- If self-employed, receipts from unincorporated business, professional enterprise, or partnership after deductions for business expenses (use business tax from previous calendar year). Include schedule K-1 (1120).
- If these charges occurred under part of a third party liability suit, please disclose this information.
- If none of the above proof-of-income applies, please provide a detailed letter explaining the means of support for you, your family or household unit.

INCOME

PATIENT'S EMPLOYER: _____ WEEKLY INCOME BEFORE TAX:$_____

SPOUSE'S EMPLOYER: _____ WEEKLY INCOME BEFORE TAX:$_____

OTHER MONTHLY INCOME: SOCIAL SECURITY..... $ _____

PENSION PLAN..... $ _____

OTHER (SPECIFY):_____ $ _____

TOTAL OTHER MONTHLY INCOME $ _____

The above statements are true and accurate. I understand that financial assistance is available only after all other sources of third party reimbursement have been exhausted. I agree to cooperate and follow through with applications for state assistance as well as any other third party payers as requested by your office. This application is subject to approval.

Applicant Signature:_____ Date:_____

CONNECTICUT DSS REGIONAL OFFICES
TOWNS SERVED & CONTACT INFO
http://www.dss.state.ct.us

****D.S.S. CENTRAL OFFICE****

25 Sigourney Street, Hartford, CT 06106 Office Hours: Monday-Friday 8:30am-4:30pm
Information and Referral: (800) 842-1508 **Toll free TDD/TTY:** (800) 842-4524

~ NORTHERN REGION OFFICES ~

Hartford Regional Office Towns Served: Avon, Bloomfield, Canton, East Granby, Farmington, Granby, Hartford, Newington, Rocky Hill, Simsbury, Suffield, West Hartford, Wethersfield, Windsor, Windsor Locks **Address:** 3580 Main Street, Hartford, CT 06120
General Information: (860) 723-1000 **TTY:** (860) 566-7913

Manchester Sub-Office Towns Served: Andover, Bolton, East Hartford, East Windsor, Ellington, Enfield, Glastonbury, Hebron, Manchester, Marlborough, Somers, South Windsor, Stafford, Tolland, Vernon
Address: 699 East Middle Turnpike, Manchester, CT 06040-3744
General Information: (860) 647-1441 **Toll-free:** (800) 859-6646

New Britain Sub-Office Towns Served: Berlin, Bristol, Burlington, New Britain, Plainville, Plymouth, Southington **Address:** 270 Lafayette Street, New Britain, CT 06053-4174
General Information: (860) 612-3400 **Toll-free:** (866) 723-2591

Willimantic Sub-Office Towns Served: Ashford, Brooklyn, Canterbury, Chaplin, Columbia, Coventry, Eastford, Hampton, Killingly, Mansfield, Plainfield, Pomfret, Putnam, Scotland, Sterling, Thompson, Union, Willington, Windham and Woodstock
Address: 676 Main Street, Willimantic, CT 06226
General Information: (860) 465-3500 **Toll-free:** (866) 327-7700

~ SOUTHERN REGION OFFICES ~

New Haven Regional Office Towns Served: Ansonia, Bethany, Branford, Derby, East Haven, Hamden, Milford, New Haven, North Branford, North Haven, Orange, Seymour, Shelton, Wallingford, West Haven, Woodbridge **General Information:** (203) 974-8000

Middletown Regional Office Towns Served: Chester, Clinton, Cromwell, Deep River, Durham, East Haddam, East Hampton, Essex, Guilford, Haddam, Killingworth, Lyme, Madison, Meriden, Middlefield, Middletown, Old Lyme, Old Saybrook, Portland, Westbrook **General Information:** (860) 704-3100

Norwich Regional Office Towns Served: Bozrah, Colchester, East Lyme, Franklin, Griswold, Groton, Lebanon, Ledyard, Lisbon, Montville, New London, North Stonington, Norwich, Preston, Salem, Sprague, Stonington, Voluntown, Waterford
General Information: (860) 823-5000 Toll-free: (800) 473-8909

~ WESTERN REGION OFFICES ~

Bridgeport Regional Office Towns Served: Bridgeport, Easton, Fairfield, Monroe, Norwalk, Stratford, Trumbull, Weston, Westport **General Information:** (203) 551-2700 Toll-free: (877) 551-2700

Stamford Regional Office Towns Served: Darien, Greenwich, New Canaan, Stamford, Wilton **General Information:** (203) 251-9300 Toll-free (866) 663-9300

Waterbury Regional Office Towns Served: Beacon Falls, Cheshire, Middlebury, Naugatuck, Oxford, Prospect, Southbury, Waterbury, Watertown, Wolcott
General Information: (203) 597-4000 **Danbury Regional Office Towns Served:** Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Sherman **General Information:** (203) 207-890

Torrington Regional Office Towns Served: Barkhamsted, Bethlehem, Canaan, Colebrook, Cornwall, Goshen, Hartland, Harwinton, Kent, Litchfield, Morris, New Hartford, Norfolk, North Canaan, Roxbury, Salisbury, Sharon, Thomaston, Torrington, Warren, Washington, Winchester, Woodbury