

**The Norwalk Hospital  
Policies and Procedures Manual**

|                  |                                          |  |                        |                              |
|------------------|------------------------------------------|--|------------------------|------------------------------|
| <b>Title:</b>    | <b>Financial Assistance Policy (FAP)</b> |  |                        |                              |
| <b>Section:</b>  | <b>Specific Department Functions</b>     |  | <b>Approved By:</b>    | <b>Patrick Minicus</b>       |
| <b>Standard:</b> | <b>Finance</b>                           |  | <b>Effective Date:</b> | <b>05/22/2009,02/19/2015</b> |
|                  |                                          |  | <b>Date Reviewed:</b>  | <b>05/22/2009,02/19/2015</b> |

**I. Purpose:**

The Norwalk Hospital Association is a not-for-profit entity established to meet the health care needs of the City of Norwalk and its surrounding communities. To the extent that the patient has financial resources, the patient or guarantor will be called upon to pay the full amount of their hospital bill. However, in accordance with its stated mission, the Hospital will provide care to individuals with limited financial resources for which it anticipates reduced or no payment from the patient. Further, it is the intent of the Hospital to meet or surpass the financial assistance requirements identified in CT. Public Act 03-266. This policy has been established to clearly delineate the procedures by which a discount from published charges will be offered to patients based on their financial inability to pay.

**II. Qualification for Financial Assistance /Determination of Amount of Financial Assistance**

***All Hospital Services Except Dental Clinic***

The Hospital's guidelines except for the Dental Clinic allow for an automatic 15 % discount off Hospital published charges regardless of income if the patient contacts Patient Accounting Customer Service expressing difficulty paying the bill. No application is required to access this discount. This discount does not apply to co-pays and deductibles for patients' balances after insurance payment.

Patients may seek further reductions in excess of 15 % by qualifying for financial assistance for all self pay balances including those resulting from insurance co-pays and deductibles. To be eligible, the patient must be deemed ineligible for government assistance and complete Norwalk Hospital's Financial Assistance Application. All legal residents of the United States will be requested to apply for Medicaid coverage.

Generally, the amount of the discount is determined by family size and income following Federal Poverty Guidelines. A format of the guidelines is found in Exhibit 1, but refer to the current year guidelines. However, consideration will also be given to the amount of the bill and the existence

of substantial debt. Assets may be considered in the financial assistance determination, if income provided in the financial assistance application does not support expenses listed, or if expenses listed do not meet a test of reasonableness. Income thresholds are based on the Federal Poverty Guidelines and updated annually. The only exceptions to these requirements are as follows:

- > Those patients known to meet the criteria because of previous history at Norwalk Hospital. For example, patients living in shelters who utilize hospital services extensively can be considered eligible for financial assistance
- > Patients who have been classified and documented as charity care cases by the Norwalk Community Health Center (NCHC) for Norwalk Hospital for a majority of outpatient services only. To be considered eligible, the Hospital requires the receipt of a written order identifying the patient as eligible for financial assistance at NCHC. These accounts will be discounted without further review at the corresponding NCHC percent discount for services, except for outpatient infusion, radiation medicine, hyperbaric services, and all inpatient services. A periodic review of discounts is undertaken to ensure the appropriateness of NCHC's financial assistance determination.
- > Pending Medicaid patients on a Medicaid spend down will automatically qualify for a financial assistance adjustment of their spend down amount.

For adult children ages 18-25, if residing at home and/or students, and being claimed as a dependent on their parents' tax return, Norwalk Hospital will look to parents/household financial data in determining financial assistance.

Patients/designee who are unable to submit financial assistance applications for legitimate reasons such as medical conditions (terminally ill, comatose), deceased, no longer residing in region or country, may still be granted financial assistance where research and/or documentation can establish reasonable certainty that patient is eligible. These accounts require approval both by the Manager, Customer Service and Director of Revenue Cycle before being granted financial assistance and documentation in the account history as to the rationale for the granting of financial assistance.

The application process for financial assistance for nonrecurring visits will be necessary for each visit unless additional visits occur within 90 days. For patients being billed on monthly recurring accounts, the eligibility for the approved financial assistance discount will be effective for 6 months from the application date. Exceptions on this policy may be deferred by Manager based on expected treatment protocol or duration of treatment.

The patient may request assistance at any point in the patient account cycle including accounts placed in collections.

Hospital services provided for non insurance covered procedures such as cosmetic and/or plastic surgery and/or bariatric services are excluded from financial assistance considerations.

### ***Dental Clinic***

The Dental Clinic follows the majority of Hospital financial assistance policies and determinations except for the following;

- > Maximum financial assistance allowed is 50% off of published charge, regardless of income levels.
- > Financial assistance determinations are good for up to one calendar year
- > All dental clinic patients requesting financial assistance are requested to apply for Medicaid.

### **III. Notification of Public**

The existence of the Hospital's Financial Assistance Program will be posted in both English and Spanish at all registration points within the Hospital.

The following patients will receive a Financial Assistance Application, also available in both English and Spanish, by Patient Access personnel at the time of registration:

- A. All ED patients who present to the Emergency Room as self pay
- B. Any patient who indicates an inability to pay

Hospital statements will clearly indicate the existence of a Financial Assistance Program including customer service telephone numbers.

All Hospital representatives must clearly indicate the existence of a Financial Assistance Policy to all self-pay patients at all points of contact. Patients inquiring about Financial Assistance, prior to services, will be referred to Patient Access Management. Patients inquiring about Financial Assistance after receiving services will be referred to the Customer Service Division of the Patient Accounting Department.

If patient files for financial assistance only after legal action has been initiated following reasonable collection efforts, the patient will be entitled to file a Financial Assistance Application but will be responsible for any legal fee costs and/or court costs incurred up to the point of time of the application.

### **IV. Other Major Procedures/Responsibilities:**

It is the responsibility of the Hospital's Access Management and/or the Customer Service Division of the Patient Accounting Department to inform patients about the details of the Hospital's Financial Assistance Policy, assist with the explanation of the Financial Assistance Application if the Application is required, determine the amount of the discount, inform the patient of the Hospital's final determination, and process the discount in the Hospital's Patient Accounting system. The only exception are [1] outpatient mental health services where the Department of Psychiatry will qualify and process financial assistance applications, and [2]

dental clinic will qualify and process financial assistance applications. The patient will have 30 days from the receipt of the application packet to return it in its entirety. Otherwise, the normal statement cycle will continue under the classification of Self Pay. When an application is received, the account status will be changed to Pending Financial Assistance and no additional statements will be sent to the patient until a final financial assistance determination is made.

## **V. Processing/Approvals**

Financial Assistance discounts will be processed in three different ways:

- 1) Recurring Monthly Accounts - Ongoing financial assistance discounts are to be processed by registering the patient with the carrier and plan reflecting the appropriate discount that will automatically reduce the account balance before billing. The two carriers to be utilized are NCHC Discount for NCHC qualified patients and Financial Assistance for all others.
- 2) Nonrecurring Episodic Accounts - The 15 % Discount which requires no financial application will be adjusted using transaction code 38026.
- 3) Nonrecurring Episodic Accounts - All other financial assistance discounts which require financial assistance applications will be adjusted using transaction Codes 48 and 26065.

Processing of Transaction Codes 48 and 26065 are subject to approvals documented in the Hospital's Write-off Authority Policy. These policies require that the Customer Service Manager must at minimum approve all financial assistance adjustments utilizing codes 48 and that the Manager of Access at minimum approve all adjustments utilizing code 26065. Individual amounts over \$ 50,000 or accounts related to the same patient which exceed \$50,000, and accounts without a formal financial assistance application [ie. deceased, terminally ill] require the signature of the Director of Revenue Cycle and notation in the patient account record of written approval.

## **VI. Documentation Requirements**

To ensure a proper audit trail, the following records must be maintained:

NCHC orders - Patient Access will retain NCHC orders classifying the patient as eligible for financial assistance for one year.

Applications/ Determinations - Patient Accounting/ Psych Business Office/Dental Clinic must track the receipt and final decisions regarding financial assistance applications by completing the Financial Assistance Application Screen in the patient's account record. Applications returned by patients must be retained for three years from the receipt of the application.

## **Exhibit 1**

**CHARITY INCOME GUIDELINES - NON ELECTIVE ADMISSIONS**  
**Effective 01/2015**

| FPG 2015 | Family Size | 100% Discount |          | 75% Discount |           | 50% Discount |           | 30% Discount |           |
|----------|-------------|---------------|----------|--------------|-----------|--------------|-----------|--------------|-----------|
|          |             | 200%          | of FPG   | 201%         | 250%      | 251%         | 325%      | 325%         | 400%      |
|          |             | from          | to       | from         | to        | from         | to        | from         | to        |
| \$11,770 | 1           | 0             | \$23,540 | \$23,541     | \$29,425  | \$29,426     | \$38,253  | \$38,254     | \$47,080  |
| \$15,930 | 2           | 0             | \$31,860 | \$31,861     | \$39,825  | \$39,826     | \$51,773  | \$51,774     | \$63,720  |
| \$20,090 | 3           | 0             | \$40,180 | \$40,181     | \$50,225  | \$50,226     | \$65,293  | \$65,294     | \$80,360  |
| \$24,250 | 4           | 0             | \$48,500 | \$48,501     | \$60,625  | \$60,626     | \$78,813  | \$78,814     | \$97,000  |
| \$28,410 | 5           | 0             | \$56,820 | \$56,821     | \$71,025  | \$71,026     | \$92,333  | \$92,334     | \$113,640 |
| \$32,570 | 6           | 0             | \$65,140 | \$65,141     | \$81,425  | \$81,426     | \$105,853 | \$105,854    | \$130,280 |
| \$36,730 | 7           | 0             | \$73,460 | \$73,461     | \$91,825  | \$91,826     | \$119,373 | \$119,374    | \$146,920 |
| \$40,890 | 8           | 0             | \$81,780 | \$81,781     | \$102,225 | \$102,226    | \$132,893 | \$132,894    | \$163,560 |

each additional \$4,060.00

**Exhibit 2**

# NORWALK HOSPITAL

|                                     |
|-------------------------------------|
| <b>For Business Office Use Only</b> |
| Date Received                       |
| Date Approved                       |
| % Approved                          |
| Authorized Signature                |

In order to process your request, please complete both sides of this financial form and submit it to the Norwalk Hospital Customer Service Department, located on the second floor across from the North Wing elevator.

**Please provide the following information and documentation:**

- 1. Two forms of ID:** A Passport, Drivers license, Visa, Social Security Card.
- 2. Proof of income:** Four current paycheck stubs or a Social Security/Pension benefits document.
- 3. A copy of most recently completed year's income tax form.**
- 4. Proof of residence/address:** A utility bill, lease agreement, mortgage document, etc.
- 5. If applicable, proof of Medicaid denial.**

**Patients Name** \_\_\_\_\_ **Date of Service**

\_\_\_\_\_

**Address**

\_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone**

\_\_\_\_\_

**Cell Phone** \_\_\_\_\_

**Name of person responsible for bill payment**

\_\_\_\_\_

**Address**

Relationship to Patient \_\_\_\_\_ Phone \_\_\_\_\_

**Dependents:**

**Name Relationship Age**

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |
|  |  |  |

Have you ever applied for public assistance or Medicaid? No \_\_\_\_\_

Yes \_\_\_\_\_

If yes, please indicate when \_\_\_\_\_

List any Health insurance information: i.e., Insurance Companies, Policy number, etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Financial Information**

**Income information:**

Patient's yearly income \_\_\_\_\_

Spouse's yearly income \_\_\_\_\_

Investment income \_\_\_\_\_

Rental Income \_\_\_\_\_

Social Security income \_\_\_\_\_

Pension income \_\_\_\_\_

401 K income \_\_\_\_\_

Food Stamps \_\_\_\_\_

Other income \_\_\_\_\_

Welfare \_\_\_\_\_

**Assets information:**

Do you own a home? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you own a vehicle? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you own stocks/bonds/mutual funds? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have any other investments? No \_\_\_\_\_ Yes \_\_\_\_\_

Norwalk Hospital reserves the right to secure additional asset information for financial assistance determination, if income provided in the financial assistance application do not support expenses listed, or if expenses listed do not meet a test of reasonableness.

**Expenses information:**

Rent or Mortgage Amount \_\_\_\_\_

Electric \_\_\_\_\_

Gas \_\_\_\_\_

Phone \_\_\_\_\_

Oil \_\_\_\_\_

Insurance Home \_\_\_\_\_

Insurance Medical \_\_\_\_\_

Insurance car \_\_\_\_\_

Taxes home \_\_\_\_\_

Taxes car \_\_\_\_\_

Loans \_\_\_\_\_

Credit cards \_\_\_\_\_

Other \_\_\_\_\_

I, the undersigned, certify that all of the above facts are true and I realize that any false statements and or information will cancel any discount approval given by Norwalk Hospital.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
\_\_\_\_\_

I also authorize Norwalk Hospital to make inquiries pertaining to my credit standing, and financial responsibility through direct contact with my creditors or credit agencies. I understand that this type of inquiry will not have a negative effect on my credit.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
\_\_\_\_\_

**Exhibit 3**

Norwalk Hospital Charity Care

It is the policy of Norwalk Hospital to provide services to any individual in need of



medical care regardless of their inability to pay. Patients who do not have insurance coverage and / or limited means to pay may qualify for a charity discount.

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. To be considered “**uninsured**”, you must meet the following requirements:

- Have one or more outstanding balances at Norwalk Hospital
- Have applied and been denied for medical healthcare coverage provided under Medicaid. (exception – individuals not eligible for applying for state assistance or a denial as a result of noncompliance with the Medicaid application process)
- Provide proof that your household income is at or below 325% of the Federal Poverty Income Guidelines.

If you have satisfied the above requirements, complete the attached Patient Financial Application and forward it along with the required documentation as noted on the application to the Customer Service Department at:

Norwalk Hospital  
Patient Accounting Department  
Attn: Customer Service Department  
24 Stevens Street  
Norwalk, Ct 06856

If you need assistance with the application process, you can call the customer service department at (203) 852-2016 or (877) 257-1949, from 8:30 am to 4:30 PM.

Or you can make an appointment or walk-in 8:30 am to 5:00 PM.

Customer Service is located on the first floor located in the Trefz Lobby.

Income will be the primary factor in determining whether a patient is eligible. However, the amount of the hospital bills and debts may be used in the determination. Please note that you will be considered “Insured” and continue to receive statements, until you provide proof that you have met the above requirements.

#### **Exhibit 4**

Norwalk Community Health Center Discount-Crosswalk

NCHC Discount Correlating Norwalk Hospital Discount

|      |      |
|------|------|
| 100% | 100% |
| 80%  | 75%  |
| 60%  | 50%  |
| 40%  | 45%  |

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