SAINT FRANCIS *Care*
BestCare for a Lifetime™

114 Woodland Street, Hartford, CT 06105

Collaborative Laboratory Services

Mount Sinai Rehabilitation Hospital
a SAINT FRANCIS *Care* Provider

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

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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

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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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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.

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** Patient Accounting	**Number** ADM 060	**Level** ☒ **System** ☐ **Division** ☐ **Department**
	Category ☒ **Administrative** ☐ **Clinical** ☐ **HR** ☐ **EOC**	**Published Date** 1/18/2016	**Review Cycle** ☒ 1 year ☐ 3 years

PURPOSE:

It is the policy of Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital (the "Hospital") 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 the Hospital for the benefit of our uninsured or underinsured patients who are unable to pay for their care. This policy reflects our commitment to individual human dignity with special concern for poor and vulnerable persons.

SCOPE:

This policy relates to all medically necessary inpatient, outpatient, clinic, and emergency department visits. Excluded from this policy are cosmetic procedures, bariatric services and secured liens on liability cases.

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 pending for thirty (30) days. A written notification will be sent to the applicant detailing the missing documentation. If the missing documentation is not provided within twenty (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 six (6) months.

3. An application for State Medical Assistance (Medicaid) must be completed for those patients with a 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 Health.

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 ranging between **200% to 400%** of the federal poverty guidelines and 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 400% 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 than the Medicare allowed amount, the patient is responsible to pay up to the Medicare allowed amount. Any amount over the Medicare allowed amount 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 200-400% of the federal poverty guidelines will be required to pay the Medicare allowed amount.

     Patients over 400% of the federal poverty guidelines will be granted the self pay discount.

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

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

PRESUMPTIVE SUPPORT:

The Hospital recognizes that not all patients are able to provide complete financial information. Therefore, approval for Financial Support may be determined based on limited available information. When such approval is granted, it is classified as "Presumptive Support." No application is required for this group.

Examples of presumptive cases include:

- Deceased patients with no known estate;
- Homeless patients;
- Patient bankruptcies;
- Members of religious organizations who have taken a vow of poverty and have no resources individually or through religious order and
- Patients who are qualified for other State Assistance Programs that are income based.

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

<$4,999 - Customer Service Rep/Financial Counselors/Team Leads
$5,000-$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 six (6) months.
- Patients with non-contracted insurance carriers or medically necessary non-covered services may be eligible for a discount up to 45%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 Vice President approval.

Nicole Schulz Vice President	Date: 1/18/2016

REPLACES:

Financial Assistance Policy 11/2/2015

1

Saint Francis Hospital and Medical Center
Community Assistance Program
Eligibility Criteria On or After 02/01/2016

2016 Poverty Guidelines

FAMILY SIZE	ANNUAL GROSS INCOME POVERTY	200%	400%
1	11,880	23,760	47,520
2	16,020	32,040	64,080
3	20,160	40,320	80,640
4	24,300	48,600	97,200
5	28,440	56,880	113,760
6	32,580	65,160	130,320
7	36,730	73,460	146,920
8	40,890	81,780	163,560
9	45,050	90,100	180,200
10	49,210	98,420	196,840

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 - 456	0 - 1,980	23,760	C	C	C	C	C	C	C	C	C	C
457 - 614	1,981 - 2,670	32,040	B	C	C	C	C	C	C	C	C	C
615 - 773	2,671 - 3,360	40,320	B	B	C	C	C	C	C	C	C	C
774 - 911	3,361 - 3,960	47,520	B	B	B	C	C	C	C	C	C	C
912 - 932	3,961 - 4,050	48,600	A	B	B	C	C	C	C	C	C	C
933 - 1,091	4,051 - 4,740	56,880	A	B	B	B	C	C	C	C	C	C
1,092 - 1,229	4,741 5,340	64,080	A	B	B	B	B	C	C	C	C	C
1,230 - 1,250	5,341 - 5,430	65,160	A	A	B	B	B	C	C	C	C	C
1,251 - 1,409	5,431 - 6,122	73,460	A	A	B	B	B	B	C	C	C	C
1,410 - 1,547	6,123 - 6,720	80,640	A	A	B	B	B	B	B	C	C	C
1,548 - 1,568	6,721 - 6,815	81,780	A	A	A	B	B	B	B	C	C	C
1,569 - 1,728	6,816 - 7,508	90,100	A	A	A	B	B	B	B	B	C	C
1,729 - 1,864	7,509 - 8,100	97,200	A	A	A	B	B	B	B	B	B	C
1,865 - 1,888	8,101 - 8,202	98,420	A	A	A	A	B	B	B	B	B	C
1,889 - 2,182	8,203 - 9,480	113,760	A	A	A	A	B	B	B	B	B	B
2,183 - 2,499	9,481 - 10,860	130,320	A	A	A	A	A	B	B	B	B	B
2,500 - 2,818	10,861 - 12,243	146,920	A	A	A	A	A	A	B	B	B	B
2,819 - 3,137	12,244 - 13,630	163,560	A	A	A	A	A	A	A	B	B	B
3,138 - 3,456	13,631 - 15,017	180,200	A	A	A	A	A	A	A	A	B	B
3,457 - 3,775	15,018 - 16,403	196,840	A	A	A	A	A	A	A	A	A	B

Sliding Scale Income Guidelines

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-$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 as uncollectible and get referred for secondary placement if over 5K.

REFERENCES:

CROSS REFERENCES: Financial Relief Policy, Emergency Medical Screening and Stabilization/ EMTALA Policy, and Bad Debt Write off 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

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 notification. These exclusions 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.

- A list of accounts eligible for bad debt greater than $5,000 are populated into an approval work queue for the Self Pay Manager, Director and Vice President.

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

$5,000-$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 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 balance will be returned to the hospital.

Accounts that are returned as uncollectible from the primary collection agency will automatically get written off as uncollectible if the balance is less than $4,999.

Account balances over $5,000 that are returned as uncollectible from the primary agency will be referred for secondary placement to a contracted collection agency. The returned as uncollectible billing indicator is applied to the account and the contracted vendor is changed to 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

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

C. REACTIVATING A BAD DEBT ACCOUNT:

EPIC: Activity 526 SFH Return from Bad Debt

D. 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.
- The following adjustment codes should be used:

	EPIC	
⇒	128	Bad Debt Wo
⇒	5015	Small Balance
⇒	5003	Bankruptcy
⇒	5063	Medicare
⇒	5051	Denied Timely Filing
⇒	5111	Presumptive Eligibility

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

E. 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.

F. 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 interruption of debt collection 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	2/17 /2016

REPLACES:
January 23, 2009 procedure

REVISED DATE: 3/21/12; 5/22/13; 1/15/2014; 4/18/2014; 1/30/2015; 5/1/2015; 2/17/2016;