Stamford Hospital

Subject:	Stamford Hospital Financial Assistance Prenatal Program (FAPPNP)
Policy # #0015	**Implemented:** 10/01/08
Reference(s):	**Revisions:**
Approval: DM, CR	**Reviewed**
Department: Patient Business Services	**Page:** 1 of 2

Purpose

Stamford Hospital Financial Assistance Prenatal Program Policy

Effective Date 10/1/2008

Pre Natal Program (FAPPNP)

I. Policy

Stamford Hospital is committed to providing financial assistance to patients seeking pre-natal care utilizing a fixed fee payment program. Services provided beyond this program will be processed through the Hospital Financial Assistance Program.

II. PROCEDURE:

1. Women who present themselves for prenatal care and are determined to be eligible for financial assistance will be offered the pre-natal program. This program does not provide coverage for the delivery or newborn care.

2. Eligibility for financial assistance is based upon financial need.
   - *a.* Stamford Hospital will use a sliding scale based on multiples of the Federal Poverty guidelines to determine the percent of financial assistance granted.
   - *b.* Stamford Hospital will consider available assets. Available assets do not include the patient's primary residence or automobiles needed for regular transportation.

3. Patients are asked to provide supporting documentation to authorized representatives to assist them in determining eligibility for Financial Assistance Programs Pre-natal (FAPPN).

4. Applications must be initially approved by one of the following authorized employees: The Optimus Financial Counselors, Stamford Hospital Financial Assistance Counselors, Stamford Hospital Patient Assistance Coordinator and designated Management personnel within the Patient Business Services Department.

5. If approved, the fixed fee cost of the program will be applicable during the months of prenatal care proceeding delivery. Payment plans should be established at the initial visit and patients will be asked to make payments at each visit. If a patient fails to comply with their payment agreement or schedule, the patient may be billed for the full charges of care provided. If the patient is truly unable to pay, the patient must request an additional review for financial assistance on the remaining balance.

6. Retroactive adjustments to patient bills may be applicable based on their current ability to pay.

Stamford Hospital

Subject:	Stamford Hospital Financial Assistance Program

Policy #	**0016**	**Implemented:**	10/01/08
Reference(s):		**Revisions:**	
Approval:	DM, CR	**Reviewed**	
Department:	Patient Business Services	**Page:**	1 of 2

Purpose

Stamford Hospital Financial Assistance Program Policy

Effective Date: October 1, 2008

Stamford Hospital Financial Assistance Program Policy

I. POLICY:

Stamford Hospital's stated mission is to provide a broad range of high quality health and wellness services focused on the needs of our communities. Stamford Hospital is committed to providing financial assistance to persons who have healthcare needs and are uninsured, under insured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation.

II. PROCEDURE:

1. The following services are eligible for inclusion under this policy:
   a. Emergency medical services provided in an emergency room setting.
   b. Services for a condition which, if not properly treated, would lead to an adverse change in the health status of an individual.
   c. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting.
   d. Medically necessary services, evaluated on a case by case basis at Stamford Hospital's discretion.

2. Eligibility for financial assistance is based upon financial need.

a. Stamford Hospital will use a sliding scale based on multiples of the federal poverty guidelines to determine the percent of financial assistance granted.

b. Stamford Hospital will consider available assets. Available assets do not include the patient's primary residence or automobiles needed for regular transportation.

3. There are instances when a patient may appear eligible for financial assistance but there is no application on file due to a lack of supporting documentation. Under these circumstances financial assistance may be granted. These situations include but are not limited to:

a. Homeless individuals with a Shelter address or unknown address where there is no means of contact after service rendered.

b. Deceased patients where it has been determined that there is no open estate or that the estate is insolvent.

c. Other situations on a case by case basis at Stamford Hospital's discretion.

4. Retroactive adjustments to patient bills may be applicable based on their current ability to pay.

5. Applications must be initially approved by one of the authorized employees of Stamford Hospital. Authorized employees are the Patient Assistance Coordinator, Financial Assistance Counselors, and designated management personnel within the Patient Business Services Department.

The Stamford Hospital

Subject: Bad Debt Procedures

Policy #	**Implemented:** 10/1/2007
Reference(s):	**Revisions:**
Approval:	**Reviewed:**
Department: Patient Business Services	**Page: 1 of 4**

Purpose

Correct referral of accounts to Bad Debt.

Policy

1. Self- pay accounts are identified in the Meditech system by financial classes 11, and 12.

2. The Financial Counselors review all inpatient accounts, clinic accounts and selective outpatient accounts for the following.
    a. Eligibility for any Federal or State Assistance Programs
    b. Payment Agreements
    c. Eligibility for Stamford Hospital Financial Assistance Program

3. The itemized statement is sent to the patient approximately 6-12 days after discharge or the date of service, depending on the patient types and when the account is final billed by the Meditech system.

4. If the accounts are not pending Federal or State Assistance, set up on a payment plan, or approved for a reduction through our financial assistance program, the following Saturday after the billing statements generate, the accounts are referred to Fitness Financial Services (a billing service, not a collection agency) for telephone contact and the follow up statement cycle.

5. Fitness Financial Services tracks the 120 days aging requirement using an automated monitoring system timeline from the date the first patient statement is generated. The patient is contacted by Fitness telephone services as a scripted “courtesy call” 30 days after the first statement was generated.

6. Following the “courtesy call”, billing statements are generated. Unless the statement is revised to “hold”, or re-sequenced at the discretion of the collector, the account is referred back to the hospital for bad debt, bankruptcy, or free service in approximately 120 days from referral.

7. The patient receives the final notice notifying them that if they fail to respond their account will be sent to a collection agency after 15 days.

8. Fitness Financial Services returned accounts and accounts with bad mailing addresses are manually reviewed, assigned to an external agency, or collection attorney and prelisted for bad debt turnover at the end of the month.

Agency Referrals

Century Financial Services

In-house collections

Upon receipt of our monthly referrals, **Letter 1** is generated to the patient or guarantor.
After **Letter 1** is sent, 30 days following, the account is assigned to a collector.
The collector attempts to make telephone contact with the patient/guarantor.
The collector will leave a message if direct contact is not made by telephone. Additional telephone follow up is performed in 7 days following the message.

The goal of the letter or telephone contact is to set up a payment contract.
A **Letter 17** is sent if the payment contract is not met.
If there is not any response to **Letter 17**, a telephone call is generated by the collector within 2 weeks.

Employment confirmation and or asset verification is conducted with 45 days of the first telephone follow up.

Letter 25, defined as a "please contact us" letter is sent to the debtor if there is not any telephone listed.

After letter 25, the account is held 15 days and then a final notice is sent.
15 days after the final notice is sent, if there is no response from the debtor,
the account(s) is sent to the Century legal department for Century legal action.

Century Legal Referrals

Conditions for legal referrals:
>In-house collectors have exhausted efforts

>Confirmed job (No self employment) or assets
>Whenever possible, accounts should not be referred to a "legal status" until 1 year from the date our account was referred to Century.
In extenuating circumstances, i.e., skips, the wait time could be decreased with prior approval from the Stamford Hospital Manager of Patient Access Business Services.

>The minimum amount referred should be $1500. This could be one account balance or the sum of multiple accounts for one patient or guarantor.

>All collection efforts should cease at any point in the process if the patient applies for free bed funds or financial assistance. If the patient does not comply or is denied assistance, collection procedures should resume.

The "authorization for suit" form is sent to the Hospital.
This form requires an authorized signature to continue "legal".
The hospital's response is one of the following:
1) Yes (Approved to go legal)
2) No Send letter writing only on attorney's stationary.
3) Close account

Stamford Hospital's collection practices do not include the use of body attachments, foreclosures or forced sales of patient's residences.

Stamford Collection Bureau (SCB)

In-house collections

Upon receipt of the Stamford Hospital monthly referrals, **Letter 1** is generated to the patient or guarantor with a notice to respond within 30 days.

The second contact is by telephone if there is no response to **Letter 1.**

Letter 2, is sent with a 20 day notice to respond.

Telephone contact is again attempted.

Depending on the case, SCB could generate up to (5) letters or (5) telephone calls.

If there is no response, whenever possible, accounts should not be referred to a "legal status" until 1 year from the date our account was referred to Stamford Collection Bureau.
The minimum amount referred should be $1500. This could be one account balance or the sum of multiple accounts for one patient or guarantor.
These accounts will be referred to the SCB collection attorney Abraham Hoffman, at 4154 Madison Avenue, Trumbull, CT 06611, with the approval of the SCB General Manager and a signed legal authorization form by the Manager of Patient Business Services at Stamford Hospital.

>All collection efforts should cease at any point in the process if the patient applies for free bed funds or financial assistance. If the patient does not comply or is denied assistance, collection procedures should resume.

Collection Attorneys

Mark Sank & Associates

Bloomental and Trow

Patient Accounts are reviewed manually, and approved by the Manager of Patient Access Business Services for direct referral to the above collection attorneys.
Accounts are directly referred to attorneys in cases where we have identified circumstances where legal proceedings will be eminent and the routine collection agency time frames or procedures would not be effective.

Upon receipt of TSH accounts, a letter is sent on Attorney's letterhead with an expected answer date within 30 days.
Accounts for deceased patient's claims are sent to the estate and researched for probate.

Letters and telephone contact vary on a case by case basis.

The Stamford Hospital will, when appropriate, utilize property liens, wage executions, payment contracts and bank executions for accounts entered into judgment and granted by the courts.

>All collection efforts should cease at any point in the process if the patient applies for free bed funds or financial assistance. If the patient does not comply or is denied assistance, collection procedures should resume.

Public Notice

Hospital bed funds may be available to help pay for your care.

Stamford Hospital also offers other financial assistance programs based on ability to pay.

To apply, contact the Patient Assistance Coordinator at 203-276-7008.

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A Planetree Hospital

30 Shelburne Road
P.O. Box 9317
Stamford, CT 06904-9317
203.276.1000
www.stamhealth.org

PATIENT NOTICE ON FINANCIAL ASSISTANCE

Stamford Hospital is proud of its not-for-profit mission to provide quality health care to the communities it serves. If you are coping with a personal financial hardship, and are facing significant debts owed to the Hospital, "bed funds" may be available to cover the cost (partially or fully) for inpatient, outpatient and emergency services rendered at the hospital for qualifying patients.

You may request to have your case presented to the Patient Access and Business Services Department to determine whether you are eligible for bed funds to the extent they are available. The Patient Access and Business Services Department has the authority to grant bed funds based on financial and personal need. [In most cases, eligibility for such funds will be based on the patient demonstrating an income level at or below two hundred and fifty (250%) of the federal poverty guidelines.]

You can obtain further information on available bed funds and an application by calling (203) 276-7008 or writing to the following address:

Patient Access and Business Services Dept.
Stamford Hospital
P.O. Box 9317
Stamford, CT 09604-9317
Attention: Public Assistance Coordinator

You will receive written notice of the outcome of your case, including reason(s) if your case is rejected. You may reapply for bed funds at any time and are encouraged to do so if your financial situation significantly worsens after the time that your initial application is rejected. Additional bed funds may also become available on an annual basis.

Other assistance options, such as a sliding scale discount available through The Stamford Hospital's Financial Assistance Program and a fixed fee pre-natal program, may also apply to your situation. The Stamford Hospital's financial counselor will inform you of these programs and other available options to assist you with your outstanding balance.

Additional support also may be available to you under various federal and state programs, including Medicare, Medicaid and state administered general assistance ("SAGA"). For more information about these programs, you can contact the hospital's Public Assistance Coordinator or your town's social service or local health department. With your written permission, your town representative can assist you with our application processes, as well as determine if you qualify for any other assistance programs such as the HUSKY program for uninsured children, the CONNPACE prescription drug program for seniors and Food Stamps.

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MR#_____ ☐ FAP ☐ Pre-natal FAP

Patient Business Service Financial Assistance Application
Complete all applicable items

Date of Request: ____/____/_____

Patient information:
Last name: _____ First Name _____ Middle Initial ___

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Address: _____ Apt # _____

City: _____ State: _____ Zip code: _____

Home Telephone# (____)_____ Work Telephone# (____)_____

Employer: _____

Employer's address: _____

Person Responsible for the bill: _____

Social Security Number: _____-_____-_____

Employer of person responsible for the bill: _____

Employer's telephone # (_____)_____

Employer's address: _____

Dependents in household:

	Name	Age	Date of Birth	Relationship to Patient
1)				
2)				
3)				
4)				
5)				

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Please provide copies of available documents on the attached list of Documentation and Verification Forms. Patients are to provide this information within 15 days of receiving the application. All information provided, discussed or recorded in relation to this application is confidential. If you have questions or require further assistance contact a Financial Assistance Counselor at (203) 276-7515 or (203) 276-7052 at the Patient Access Business Department

Additional information that the applicant wishes to be taken into consideration:

_____

_____

_____

I hereby request financial assistance from Stamford Hospital, including access to hospital bed funds that may be available and for which I may be eligible. I understand that the information which I have submitted is subjected to verification by Stamford Hospital. I certify that the above information is true and correct. I understand that I may be asked to apply for public assistance, if eligible.

Applicant's Signature: _____ Date:_____

Please note that failure to complete this application and provide the information requested within the time allotted will delay processing of your request and may result in a determination that you are not eligible for financial assistance.

FOR HOSPITAL USE ONLY

Bed Fund Approved: _____ Account #: V_____ Denied: _____

Reason for Denial: _____

Financial Assistance Approved: _____@_____% Denied: _____

Reason for Denial: _____ Date: _____

By: _____ Date: _____

Amount of Adjustments: $_____ Code: _____

Completed by: _____ Date: _____

Form Taken By:_____

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Documentation and Verification Forms

Please provide available documents listed below to your Financial Assistance Counselor or the Patient Access Business Services Department.

PLEASE PROVIDE US WITH COPIES OF THE FOLLOWING DOCUMENTATION :

☐ Department of Social Services Denial Letter

Insurance:

Health - ☐ YES or ☐ NO

Workers comp - ☐ YES or ☐ NO

Liability - ☐ YES or ☐ NO

MVA - ☐ YES or ☐ NO

Identification:

☐ Photo ID / Passport / Permanent Resident Card

☐ Proof of Address (utility bills, cable, telephone)

☐ Children's Birth Certificate / Insurance Card(s)

Income:

☐ Most Recent Tax Return

☐ Most Recent W-2 or 1099

☐ Pay Stubs for last month (4 weekly / 2 bi-weekly)

☐ Notarized letter from employer or self

☐ Alimony and Child Support

Assets:

☐ Most recent Bank Account Statement (Checkings, Savings, CD's)

☐ YES or ☐ NO if no, please initial _____

☐ Do you own Property other than the primary residence?

☐ YES or ☐ NO if yes, rental income $_____

Residence Information:

☐ Rent Receipt / Mortgage Statement

☐ Notarized letter from landlord or self

☐ Shelter letter

Pre-natal:

☐ Pre-natal contract (Optimus/TSH contract)

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MR#_____ ☐ FAP ☐ Pre-natal FAP

Departamento de Servicios al Paciente Asistencia Financiera
Complete todo lo que le aplique

Fecha: ____/_____/_____

Información del Paciente:
Apellido: _____ Primer Nombre:_____

Fecha de nacimiento: ____/___/_____ Numero de Seguro Social: ____-_____-____

Dirección: _____ # de Apt: _____

Ciudad: _____ Estado:_____ Zona Postal: _____

Teléfono de la casa: (____)_____ Teléfono del empleo: (___)_____

Empleo: _____

Dirección del Empleo: _____

Persona responsable de la(s) factura(s): _____

Numero de Seguro Social: _____

Empleo de la persona responsable: _____

Teléfono del empleo: (____)_____

Dirección del empleo: _____

Personas a su cargo:

	Nombre	Edad	Fecha de Nacimiento	Relacion al Paciente
1)				
2)				
3)				
4)				
5)				

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Favor de proveer copias de los documentos disponible en la lista de documentos. Favor de traer los documentos antes de 15 días del día que se le fue dado el formulario. Toda la información sometida por escrito, verbal o gravada en relación con el formulario es confidencial. Si tiene preguntas o necesita mas información por favor llamar a un Consejero(a) Financiero(a) al numero (203) 276-7515 o (203) 276-7052 en el Departamento de Servicios al Paciente.

Información adicional que el aspirante quiera que sea tomado en consideración:

_____

_____

_____

Por este medio pido ayuda Financiera al Hospital de Stamford, inclusive acceso a fondos de cama de Hospital que pueden estar disponibles. Yo comprendo que la información que he sometido esta sujeta a verificación por el Hospital de Stamford. Certifico que la información dada es la correcta y verdadera. Entiendo que me pueden pedir que aplique para asistencia publica, si fuera elegible.

Firma del Aspirante: _____ Fecha: ____/___/_____

Sin la información dada o no dar prueba para procesar el formulario en el tiempo indicado podría resultar en negación de la ayuda financiera o no ser elegible para el programa.

USO DEL HOSPITAL DE STAMFORD

Fondos para cama del Hospital: _____ Cuenta: V_____ Negada _____

Razón para ser negada: _____

Asistencia Financiera Aprovada: _____@_____ %Negada _____

Razón por ser negada: _____ Fecha_____

Procesador: _____ Fecha_____

Suma ajustada: $_____ Codigo: _____

Prosesador:_____ Fecha:_____

Formulario recibido por:_____

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LISTA DE DOCUMENTOS

Favor de proveer copias de los documentos disponible.

☐ Copia de la carta en la cual el departamento de Servicio Social indica Que no es elegible

Seguro:

Medico - ☐ SI o ☐ NO

Compensación de Trabajo - ☐ SI o ☐ NO

Liability - ☐ SI o ☐ NO

Auto - ☐ SI o ☐ NO

Identification:

☐ Identificación con foto / Pasaporte / Tarjeta de Residencia

☐ Prueba de dirección (utilidades, teléfono, cable)

☐ Certificado de nacimiento de los niños / Tarjeta de Seguro Medico

Ingresos:

☐ Copia de la ultima planilla de impuestos (taxes) o formularios W2 / 1099

☐ Copia de los talonarios mas recientes de cheque del ultimo mes

☐ Carta Notarizada de su empleo

☐ Si no trabaja una carta notarizada indicando como se mantiene

☐ Carta de Manutencion de hijos

Finanzas e Inversiones:

☐ Información de cuenta de banco

☐ SI o ☐ No por favor the poner sus iniciales si no tiene cuenta de banco _____

☐ Es dueno de otra propiedad que no sea su propiedad princinpal?

☐ SI o ☐ No

Usted la usa para Ingreso? ☐ SI o ☐ No

Cuanto recibe mensual $_____

Informacion Residencial:

☐ Recibos de renta

☐ Carta notarizada de su propietario

☐ Alberge / Refugio

Pre-natal:

☐ Contrato Pre-natal (Optimus/TSH contract)

TSH FINANCIAL ASSISTANCE CALCULATION TABLE

Based on Federal Poverty Guidelines Effective 02/2009

	A	B	C	D	E	F	G
			FAP -Level 0 100%	FAP -Level 1 90%	FAP -Level 2 80%	FAP -Level 3 70%	FAP -Level 4 60%
	Family Unit Size	FEDERAL Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)
Income Per Year	1	$10,830	$21,660	$27,075	$32,490	$37,905	$43,320
Income Per Year	2	$14,570	$29,140	$36,425	$43,710	$50,995	$58,280
Income Per Year	3	$18,310	$36,620	$45,775	$54,930	$64,085	$73,240
Income Per Year	4	$22,050	$44,100	$55,125	$66,150	$77,175	$88,200
Income Per Year	5	$25,790	$51,580	$64,475	$77,370	$90,265	$103,160
Income Per Year	6	$29,530	$59,060	$73,825	$88,590	$103,355	$118,120
Income Per Year	7	$33,270	$66,540	$83,175	$99,810	$116,445	$133,080
Income Per Year	8	$37,010	$74,020	$92,525	$111,030	$129,535	$148,040
	Each addtl.: Add	$3,740					
			FAP -Level 0 100%	FAP -Level 1 90%	FAP -Level 2 80%	FAP -Level 3 70%	FAP -Level 4 60%
	Family Unit Size	FEDERAL Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)
Income Per Month	1	$903	$1,805	$2,256	$2,708	$3,159	$3,610
Income Per Month	2	$1,214	$2,428	$3,035	$3,643	$4,250	$4,857
Income Per Month	3	$1,526	$3,052	$3,815	$4,578	$5,340	$6,103
Income Per Month	4	$1,838	$3,675	$4,594	$5,513	$6,431	$7,350
Income Per Month	5	$2,149	$4,298	$5,373	$6,448	$7,522	$8,597
Income Per Month	6	$2,461	$4,922	$6,152	$7,383	$8,613	$9,843
Income Per Month	7	$2,773	$5,545	$6,931	$8,318	$9,704	$11,090
Income Per Month	8	$3,084	$6,168	$7,710	$9,253	$10,795	$12,337
	Each addtl.: Add	$311.67					
			FAP -Level 0 100%	FAP -Level 1 90%	FAP -Level 2 80%	FAP -Level 3 70%	FAP -Level 4 60%
	Family Unit Size	FEDERAL Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)
Income Per Week	1	$208	$417	$521	$625	$729	$833
Income Per Week	2	$280	$560	$700	$841	$981	$1,121
Income Per Week	3	$352	$704	$880	$1,056	$1,232	$1,408
Income Per Week	4	$424	$848	$1,060	$1,272	$1,484	$1,696
Income Per Week	5	$496	$992	$1,240	$1,488	$1,736	$1,984
Income Per Week	6	$568	$1,136	$1,420	$1,704	$1,988	$2,272
Income Per Week	7	$640	$1,280	$1,600	$1,919	$2,239	$2,559
Income Per Week	8	$712	$1,423	$1,779	$2,135	$2,491	$2,847
	Each addtl.: Add	$71.92					

This chart indicates the criteria for income used to determine if patients are eligible for financial assistance at Stamford Hospital. For each family size unit in Column A, income levels are listed that determine free service based either on yearly, monthly , or weekly incomes. Column B indicates the Federal poverty guidelines, while Columns C through G indicates based on the patients family income, the appropriate level for the Financial Assistance Program [See Below] These income levels are in direct relationship to the federal poverty guidelines which are determined by the US Govt on a yearly basis. The number in the (X_) indicates the multiplier applied to Column B to determine the Stamford Hospital Guidelines.

Level 0 100% adjustment to patient's account balance*

* Self pay patients are asked to pay what they can afford prior to or at the time of service. Amounts collected prior to, or at the time of service are not refundable.

Level 1 90% adjustment to patient's account balance. Patient is responsible for paying 10% of the remaining balance

Level 2 80% adjustment to patient's account balance. patient is responsible for paying 20% of the remaining balance

Level 3 70% adjustment of patient's account balance. patient is responsible for paying 30% of the remaining balance

Level 4 60% adjustment of patient's account balance. patient is responsible for paying 40% of the remaining balance

Income

Financial Assistance (FAP) applications may be accepted and considered for inpatient and outpatient services.
Applications for financial assistance will require verifiable proof of income and/or assets (i.e., W-2 forms, tax return, payroll check stubs, statements from employer, bank records, tax records, etc.
All other avenues to obtain financial assistance and third party payment must be exhausted prior to receiving financial assistance.

Assets

The applicant's primary residence and primary vehicle will be exempt from inclusion of assets.
Any additional real and personal property may be used in the evaluation in determining financial assistance.
The amount of cash in savings and checking accounts will also be used in determining financial assistance.
It is the responsibility of the applicant to provide, upon request, adequate documentation of checking/savings accounts.
Acceptable documentation will consist of current bankbooks or statements.

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Hospital Bed Funds Policy and Procedures

This policy and procedure rescinds all other policies and procedures and memoranda relating to this subject issued prior to November 2004. Stamford Hospital and pertinent outpatient treatment centers and clinics are referred to collectively in this policy as the Hospital.

PURPOSE

To outline the Hospital's policy and procedures for providing access to hospital bed funds for eligible patients in a manner consistent with the intent of the donors of such funds and the Hospital's mission to provide medical care in a compassionate and caring manner.

DEFINITIONS

"Hospital Bed Funds" or "Funds" means any gift of money, stock, bonds, financial instruments or other property made by any donor for the purpose of establishing a fund to provide medical care, including, but not limited to, inpatient or outpatient care, to eligible patients of the Hospital, being patients who have financial need.

"Eligible Patients" means those patients designated as eligible recipients in the gift instrument or other documentation establishing the Fund or, to the extent such designation is not made or is no longer applicable for any reason, patients who demonstrate financial need as determined by the Hospital following examination of available income, assets and such other information as may be required.

"Collection Agent" means any person, either employed or under contract to the Hospital who is engaged in the business of collecting payment from consumers for medical services provided by the Hospital, and includes, but is not limited to, attorneys performing debt collection activities.

OBJECTIVE OF POLICY

To administer Hospital Bed Funds effectively and efficiently, and ensure the Hospital is in compliance with Conn. Gen. Stat. §19a-509b, as amended by Public Act 03-266.

STATEMENT OF POLICY

It is the policy of the Hospital to provide its patients with the opportunity to apply for Hospital Bed Funds that may be available from time to time and to grant such Funds to Eligible Patients in order to help reduce or eliminate the cost of their medical care. Distribution of Hospital Bed Funds shall be made in accordance with the instructions of the fund donors and, to the extent such instructions are not provided or not applicable for any reason, in accordance with the procedures set forth below.

PROCEDURES

1. The Hospital shall at all times cause to be posted the public notice ("Notice") attached hereto at Exhibit A regarding the availability of Hospital Bed Funds. The Notice shall be posted in English and Spanish in conspicuous places in each patient admitting location of the Hospital including, but not limited to, the admissions offices, emergency room, social services department and patient accounts/billing offices.

2. The Hospital shall also make available the one page summary ("Summary") attached hereto at Exhibit B describing Hospital Bed Funds and how to apply for them. The Summary shall be available in various locations throughout the Hospital, including, but not limited to, the admissions offices, emergency room, social services department and patient accounts/billing offices. The Summary shall also be available from any Collection Agent and provided directly to patients if during the admission process or during the review of the financial resources of the patient, patient registration personnel, financial counselors or other employees of the Hospital believe the patient will have limited funds to pay for any portion of the patient's hospitalization not covered by insurance. In addition, the Summary shall be included in all bills and collection notices sent by Collection Agents.

3. The Hospital will provide training to all relevant staff, including, but not limited to, its financial counselors, social workers, discharge planners and billing personnel concerning the existence of Hospital Bed Funds, eligibility requirements and the procedures for application. This training program shall be overseen by the Patient Access Business Services Department.

4. Patients applying for Hospital Bed Funds shall be furnished with the application form ("Application") attached hereto at Exhibit C. Financial counselors in the Patient Registration Department shall assist Hospital inpatients with the Application process while financial counselors assigned to the Hospital's ambulatory clinics and Customer Service Department shall perform the same function for outpatients and/or post-discharge patients seeking to apply. All patients, including, but not limited to, Medicare and Medicaid beneficiaries seeking relief from cost-sharing amounts, shall be permitted to apply for Hospital Bed Funds at any time during or after their hospital stay or outpatient visit.

5. The Hospital's Finance Department, working in collaboration with the Stamford Health Foundation ("SHF"), shall keep a listing of all Hospital Bed Funds that are available to Eligible Patients. This listing shall contain the names of all Funds, an internally assigned account number and set forth all relevant eligibility criteria and restrictions concerning use of the Funds. The listing shall be updated periodically to reflect available Funds and current Fund balances, and be distributed to the following personnel: Chief Financial Officer, Senior Vice President of SHF, Executive Director of Finance, Executive Director of Patient Access Business Services, Manager of Patient Access Business Services, Director of Clinical Compliance, Public Assistance Coordinator and all financial counselors involved in the Application process.

6. The documentation and verification requirements for determining whether an applicant will be deemed an Eligible Patient for purposes of receiving any Hospital Bed Funds that may be available shall be based on the criteria established by the Fund donor or, to the extent such criteria is not provided or not applicable for any reason, by the applicant providing the information required under the Hospital's Financial Assistance Program

("FAP") to demonstrate financial need. Once the applicant is deemed an Eligible Patient, the Patient Access Business Services Department shall determine the amount to be granted from any available Hospital Bed Funds based on the parameters established by the Funds or, if none exist, the particular facts and circumstances of the case.

7. In distributing Hospital Bed Funds, the Public Assistance Coordinator shall have authority to grant amounts up to $5,000. Awards that exceed $5,000 but are less than $25,000 shall require the approval of the Manager of the Patient Access Business Services Department while awards of $25,000 and above shall require the approval of the Executive Director of the Patient Access Business Services Department. The amounts awarded shall be applied against the Eligible Patient's outstanding bill and shall not be paid directly to any individual. Upon approving any award of Hospital Bed Funds, the Patient Access Business Services Department shall file a report with the Patient Billing Office, Executive Director of Finance and the Executive Vice President of SHF for purposes of deducting the amount from the Eligible Patient's bill as well as the listing of available Hospital Bed Funds.

8. Unless specified otherwise in the gift instrument or other documentation establishing the Funds, the Hospital shall only grant Hospital Bed Funds to cover medically necessary inpatient or outpatient services provided to residents of Stamford, Darien and New Canaan, Connecticut. The Hospital's Patient Access Business Services Department shall apply the same standards as used under the FAP for purposes of determining medical necessity.

9. Applicants for Hospital Bed Funds shall be notified in writing of any award or rejection and the reason for such rejection within fifteen (15) days of submitting an Application and all income or other verification information that is required.

10. The Hospital shall not refer a patient's account to any Collection Agent or initiate an action against the patient or the patient's estate to collect fees arising from the care provided at the Hospital unless it has made a determination whether the individual is an uninsured patient, as defined in Con. Gen. Stat. §19a-673, and is not eligible for Hospital Bed Funds. If at any point in the debt collection process, the Hospital or any of its agents or employees becomes aware that the debtor is eligible for Hospital Bed Funds, free or reduced price hospital services, or any other program that would result in the reduction or elimination of the debt due the Hospital, collection efforts shall be promptly discontinued and the collection file shall be referred to the Patient Access Business Services Department for a determination of such eligibility. Collection efforts shall not resume until the eligibility determination is made.

11. The Patient Access Business Services Department in conjunction with the Executive Director of Finance shall maintain and annually compile, at the end of each fiscal year, the following information: (1) the number of applications for Hospital Bed Funds; (2) the number of patients receiving Hospital Bed Fund grants and the actual dollar amounts provided to each patient from such Funds; (3) the fair market value of the principal of each individual Hospital Bed Fund, or the principal attributable to each Fund if held in a pooled investment; (4) the total earnings for each Hospital Bed Fund or the earnings attributable to each Fund; (5) the dollar amount of earnings reinvested as principal in Hospital Bed Funds, if any; and (6) the dollar amount of earnings available from Hospital Bed Funds available for patient care. This information shall be permanently retained by the Patient Access Business Services Department and made available to the Office of Health Care Access upon request.