

THE UNIVERSITY OF CONNECTICUT HEALTH CENTER  
JOHN DEMPSEY HOSPITAL, UMG/UHP  
ADMINISTRATIVE MANUAL

SECTION: FINANCIAL MANAGEMENT

NUMBER: 04-005

SUBJECT: CHARITY CARE

PAGE: 1 OF 3

PURPOSE:

To provide a policy and procedure for the determination and handling of University of Connecticut Health Center's (UHC) Charity Care. Charity Care is a financial assistance program offered by the UConn Health Center which provides a reduced cost rate for medically necessary services incurred by State of Connecticut legal residents whose household income does not exceed 250% of the Federal Income Poverty Guidelines for a family unit.

Patients must meet the State of Connecticut definition of "Uninsured", having applied and been denied eligibility for any medical or health care coverage provided under the General Assistance Program or the CT Medicaid program, or not be eligible for coverage under the Medicare or CHAMPUS programs, or any other governmental or privately sponsored health or accident insurance. Patients must furnish proof of income to qualify for charity care.

PROCEDURE:

A. Notice of Charity Care:

Signs in both English and Spanish are posted in the operational areas indicated below:

Health Center Cashier Offices  
Financial Counseling Offices  
Hospital outpatient departments  
Patient Financial Services departments  
Hospital Emergency department  
Same Day Surgery department  
**UMG/UHP Physician Offices**

B. Applications for Charity Care:

Patients may obtain an application for Charity Care from Financial Counselors or the Collection units of the Patient Financial Services Department. The completed application must be returned to the attention of the Collections Supervisor of the Patient Financial Services Department.

Financial Counselors, Case Managers, and Social Workers are available to assist the patient with this process. Additionally, UConn Health Center has translation services available through the Language Line services via AT&T to also assist with this process.

C. Eligibility Requirements

All patients who apply for Charity Care consideration must be State of Connecticut legal residents whose household income does not exceed 250% of the Federal Income Poverty Guidelines for a family unit. Patients must meet the definition of "Uninsured", having applied and been denied eligibility for any medical or health care coverage provided under the General Assistance Program or the CT Medicaid program, or not eligible for coverage under the Medicare or CHAMPUS programs, or any other governmental or privately sponsored health or accident insurance. Patients must furnish proof of income to qualify for charity care.

Federal Income Poverty Guidelines will be adjusted annually based upon the inflation rate as determined by the Consumer Price Index (CPI) as published at the end of the calendar year.

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D. Services Covered by the Program:

**Medically necessary services**, which are deemed essential to identify or treat a patient's condition, illness or injury, based on the patient's symptoms, diagnosis or treatment of the underlying condition, in accordance with professional standards of medical care generally accepted in the medical community.

E. Services NOT Covered:

**Not medically necessary services**, which are solely for the convenience of the patient

Disputes with respect to medically necessary services may be appealed to the Associate Dean for Clinical Affairs

F. Application Documentation Requirements:

1. Applications must include documentation of all household income. The required form of documentation will be one or more of the following:
  - a. Pay stubs for the previous three (3) months
  - b. The previous year's income tax return (Schedule C for self-employed applicants)
  - c. The previous year's W-2 form
  - d. Social Security verification of monthly pension
2. Patient's whose income is known to exceed the poverty income guidelines must also provide documentation of their assets, which incorporate the following items:
  - a. Savings and passbook accounts
  - b. Stocks, bonds, and certificates of deposit
  - c. Money market accounts
  - d. Annuities
  - e. Pensions
3. Applications must include documentation of unpaid UCHC expenses. Any unpaid UCHC expenses must be documented by a billing invoice and a balance due statement.
4. Proof of State of Connecticut legal residency.

G. Eligibility Determination

1. An applicant will be considered eligible for Charity Care consideration only if eligibility and documentation requirements are met, and the application is returned within 90 days of receipt.
2. After making the eligibility determination, the Collection Supervisor or their designee will notify the patient of the decision in writing within three business days.
3. Approved Charity Care applications will cover only those services where payment is due from the patient at the time of the eligibility determination. Patients may reapply for Charity Care on a per episode basis. Also, if additional services are requested related to the current treatment, those services will be covered as well under the initial application

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H. Collection Procedure

1. Normal billing procedures will continue during the application process. However, the account will not be referred to an outside collection agency, or if the account is already with an outside collection agency, collection efforts will be delayed until final determination is made on the patient's eligibility for Charity Care.
2. Control logs are maintained by the collection department for John Dempsey Hospital (JDH) and University Medical Group (UMG) to record allowances processed by fiscal year and will include the transaction date, the patient name and patient visit number(s), the transaction amount and the year to date total. The JDH control log is made available to the State of Connecticut's Office of Health Care Access upon request. Applications will be retained for a six (6) month period after the end of the fiscal year and logs are retained for permanently for audit and statistical purposes.

Date Issued: 2/95

Date Reviewed: 10/95; 10/97

Date Revised: 12/97, 10/01, 11/01, 7/03, 1/05; 01/07; 06/08; 02/09



University of Connecticut  
Health Center

John Dempsey Hospital  
Patient Services Department  
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March 9, 2010

TO: Richard Peer, Director Patient Financial Services

FROM: Benjamin Maysonet, Collection Supervisor Patient Financial Services

Re: Collection Plan

What follows are the policies Benjamin and I came up with relating to the organization and procedures relating to our self pay A/R. Its content is broken into the following parts:

- I. Outside Collection Agencies
- II. Payment Contracts
- III. Accounts Receivable
- IV. Collection Process
- V. Patient Access Pay Plans
- VI. Miscellaneous

Cc: Benjamin Maysonet, Collection Supervisor

## **John Dempsey Hospital Patient Financial Services Self Pay Collection Policy**

### **I. ACCOUNTS RECEIVABLE**

The policy of the collection unit is that all accounts are due and payable within 120 days of the date they become self-pay. Before we actively work the self pay receivables in this manner, we must be comfortable with the attitude that once the account is self pay that it is self pay “for life”, and any and all reasonable attempts have been made to collect the account from other payment sources.

#### **1. Small accounts (under \$500)**

The patient/guarantor would receive a first dunning statement giving them 30 days for full payment or contact from them. If no activity after 30 days, the patient/guarantor receives a second and final dunning statement demanding payment within 30 days. If no response at all after 60 days, the account should be forwarded to a collection agency.

#### **2. Mid range accounts (\$501 - \$999.99)**

The patient/guarantor would receive a first dunning statement giving them 30 days for full payment or contact from them. If no activity after 30 days, the patient /guarantor receives a second and final dunning statement demanding payment within 30 days.

We make an attempt to contact the patient/guarantor 2 or more times to determine their ability to pay after the first dunning statement is sent. If no response at all after 60 days, the account should be forwarded to a collection agency.

#### **3. Large accounts (over \$1,000)**

The patient/guarantor would receive a first dunning statement giving them 30 days for full payment or contact from them.

We make an attempt to contact the patient/guarantor 2 or more times to determine their ability to pay after the first dunning statement is sent.

After 60 days, we call the patient/guarantor one final time and follow up with one final dunning statement if the patient still has not responded. If

the patient does not respond to this inquiry, the account can be referred over to a collection agency or the Connecticut Attorney General's Office (account balances over \$2,000 with assets).

If you identify insurance coverage for a visit, or if a patient provides insurance information for a visit, or if a visit has been incorrectly denied by the insurance company, you can have the patient's visit billed to the insurance carrier by the Insurance Billers. Before any insurance rebilling can occur, you must verify that there is insurance coverage effective for the date of service and services rendered. After verification, the account balance should be transferred to the insurance Financial Class.

## II. COLLECTION PROCESS

- The Collection Staff will use the following methods to contact the patient:
  - 1) Home telephone number
  - 2) Place of Employment number
  - 3) Cell phone number
  - 4) Relative or other number
  - 5) Template letter series
- When contacting the patient /guarantor for payment, always identify yourself and the Hospital, make sure you have identified who you are speaking with, and demand payment in full. Always conduct yourself in an appropriate and businesslike manner. Do not discuss any aspect of the patient's medical condition during these conversations.
- The Collection Staff can contact the following persons regarding a patient's outstanding balance:
  - 1) Patient/Guarantor
  - 2) A spouse regarding the balance the patient owes or if the patient gives permission to discuss the patient's detailed services.
  - 3) A Power of Attorney assigned to handle the patient's medical bills (proof is required).
  - 4) A Conservator assigned to handle the patient's medical bills (proof is required).
  - 5) A patient/guarantor's attorney if a signed HIPAA authorization from the patient/guarantor giving their Attorney the right to discuss the patient's medical bills is provided.
  - 6) Interpreters who assist the patient if the patient/guarantor is Bilingual.
  - 7) Relatives or friends of patient/guarantor after they give permission.
  - 8) Other Third Parties if the patient is deaf or blind after the patient/guarantor Gives permission.

- The Collection Staff will use the following tools to skip trace an account when the contact information is outdated:
  - 1) Use of Town Websites to verify property.
  - 2) Use the Internet to locate new listings for the patients (Example: 411.com or switchboard.com).
- The Collection Staff must have knowledge of the Privacy Laws & how they apply. (Example: UCHC policy on privacy; HIPAA (Federal Law); HITECH (Federal Law)).
- The Collection Staff checks assets for balances \$2,000+ to determine if the files should be referred to the Connecticut Attorney General's Office or to a collection agency. To check for assets, use town websites or town assessor's offices to verify property ownership and contact listed employers to verify employment status.
- The Collection Staff sends Charity Care Applications to uninsured patients in need of financial assistance. The Collection Staff also reviews the Charity Care Application to make sure the application for assistance is accurate and complete. Once complete, it should be given to the Collection Supervisor for final review for approval or denial.
- The Collection Staff interviews the patient over the phone to see if they qualify for the Brainard/Murphy Fund which is governed by the Hartford Foundation for Public Giving . This program assists patients in paying their medical bills, and who need to protect their assets who meet the fund criteria.

### III. PAYMENT CONTRACTS

A) In-house Budget Plans are to be administered under the following guidelines:

- Payment plans for account balances under \$100.00. These must be paid in 2 installments within 60 days.
- All pay plans must require an up-front deposit of 5%-25% and be subject to the following guidelines:

Balances Between \$101 and \$500.00 to be paid within 4 months

Balances Between \$501 and \$1,000.00 to be paid within 8 months

Balances Between \$1,001 and \$2,000.00 to be paid within 12 months



Balances Over \$2,000.00 to be paid 12+ months on the discretion of the Collection Supervisor

- A payment Contract form must be sent to the patient/guarantor for their signature acknowledging acceptance of this agreement. (see attachment A)

If a patient cannot meet the following obligations, he or she may be eligible for a sliding scale discount under a sliding scale arrangement similar to our present Charity Care scale or a Temporary Reduced Budget Plan ( **See Section II-B**). This discount would go into effect after the patient met the arrangement. This sliding scale and the eligibility requirements are updated annually when the Federal Poverty Guidelines are posted by the Federal Government February of each year.

If a patient defaults on their monthly payment twice within a six month period, the account will be referred to a collection agency. Any missed payments must be added to the next month's payment.

If subsequent admissions occur after the terms of the pay plan are agreed to, the monthly installment will be recalculated.

Any patient who does not agree to our terms of payment plans, does not qualify for a discount under a sliding scale, Charity Care or defaults on their payment plan shall have their balance referred to our collection agency for administration.

Payment Contract accounts will receive a monthly statement to remind them of their payment due for which they would send in the stub from their dunning statement with each payment in the return envelope supplied.

Settlements can be done by the Collection Staff up to 20% of the balance due after the patient notifies the staff member of their financial situation. If more than a 20% discount is required, the Collection Supervisor or Patient Access Supervisor can assist the patient with up to a 40% discount. If a discount over 40% is needed, the Director of Patient Financial Services will make the determination if a larger discount is warranted. Payment is due within 7 days of agreement. Detailed notes explaining the discount must be entered on the visit.

#### B) Temporary Reduced Budget Plans

- Patients that can't make payment in full, make a minimum down payment or make the standard Budget plans, may be eligible for a Temporary Reduced Budget Plan. A deposit should still be demanded from 5% to 25% on a Temporary Reduced Budget Plan but can be waived.
- A Temporary Reduced Budget Plan is good for 6 months. Patients must provide a satisfactory reason why they are unable to pay under the Standard Pay Plan. Once documented in Web IDX, collectors have authority to grant this based on the patients needs

Less than \$100.00- minimum to accept is \$20/MO.  
Between \$101-\$500- minimum to accept is \$25/MO.  
Between \$501-\$1,000- minimum to accept is \$25/MO.  
Between \$1,001- \$2,000- minimum to accept is \$25/MO.  
Between \$2,000- \$2,499- minimum to accept is \$25/MO.  
Greater than \$2,500+ Collection Supervisor is to review

- A monthly report will be provided to monitor the status of all Budget Plans.  
Patients who have defaulted on all Temporary Reduced Budget Plans, should be referred to outside collection agencies.

#### IV. SETTLEMENTS

There are occasions when John Dempsey Hospital will negotiate a settlement or discount on a patient's balances when they have no insurance coverage or have a self-pay balance due.

Negotiated settlements are offered as an incentive for quick payment of self-pay balances, to reduce the hospital's accounts receivable and lower collection agency expense. Settlements are not to replace our efforts to collect payment in full on self-pay balances. Before any negotiated settlement is offered, there must be a documented attempt to collect the entire self pay balance, and a reason why the settlement offer is appropriate.

Negotiated settlements can be arranged by the Collection Agency.

##### Self Pay Definitions

-Meets State of Connecticut definition of uninsured (should be eligible for charity care)

OR

-Self-pay, no insurance coverage

OR

-Balance after insurance payment

##### Criteria for settlements

- Balances must be over \$100.00  
The patient's self-pay balances must be over \$100.00 to be considered.
- Only services and charges already incurred are eligible.  
Settlements cannot be negotiated for future services.
- Settlements can be approved for up to 40% of the self-pay balance.
- All settlements exceeding an adjustment of \$500 need JDH manager's approval.  
Any settlement exceeding an adjustment of \$1,000 needs JDH Director's approval.
- Payment in full of the remaining self pay balances
  - No adjustment will be made to the account until full payment of the balance that will remain has been received.

- This payment must be received within 7 business days. With the JDH manager's approval, it can be extended.

*Guide lines*

% of adjustments

Who can approve

0-20%

Collection Agency

20-40%

Collection Supervisor JDH

40% or greater

Director, Patient Financial Services JDH

V. PATIENT ACCESS PAY PLANS

- The Patient Access Department of the Hospital will assist in collecting upfront payments from the patients who need assistance in paying the services. The following is the policy of the Department of Patient Access:
  - 1) JDH – Diagnostic and Surgical Procedures paid in full prior to service 20% discount. The Patient Access Staff must inform patient that this is an estimate. Patient will also receive a 20% discount on balances.
  - 2) If patient cannot pay in full, collect 50% of the estimated charges this must be collected prior to services. If patient cannot pay 50% of estimated charges, please see Patient Access Supervisor or Director for instructions. In the event Patient Access Supervisor or Director are unavailable, the Patient Access Staff can be advised by Collection Supervisor or Director of Patient Financial Services.

VI. OUTSIDE COLLECTION AGENCIES:

We require our Collection Agencies to do the following processes:

1. Administration of payment plans that we refer to them.
2. Send out dunning statements to patient/guarantor..
3. Regular collection activities.
4. Usage of the Hospital A/R automated system to collect information if available.
5. Settlements up to 20% to assist in collecting accounts without contacting the Hospital Collection Supervisor. If over 20% settlement is needed, the Collection Agencies contact the Collection Supervisor who will in turn make a determination of how much discount will be given. If over 40% is required, the Director of Patient Financial Services makes the determination.
6. The Collection Agencies notifies the Hospital Collection Supervisor in the event the patient wants to file for the Charity Care Program.

We require the collection agency be fully automated and computerized so they can swap and download diskettes or via secured download using other software with us.

## VII. MISC

A Credit and Collection policy should be available and given to patients in admitting for inpatient bills and in the following units:

- Rehab Services
- Day surgery
- Psych clinic and day treatment center

We have placed on the statement dunning notice 1, 2, 3 & 4 that reflects the acceleration of the dunning to each patient. These statements coincide with the C & C policy.

The sliding scale are approved or denied by the Collection Supervisor for Psych Clinic as well as the Outpatient Therapy services (OPS). The Collection Staff will review and adjust any patient balances that were approved for sliding scale.

The Collection Supervisor will review and approve all Charity Cares, and do the proper adjustments as needed up to \$4,999.99.

The Director of Patient Financial Services will review all Charity Care applications above \$5,000.00+ with the Collection Supervisor adjusting the balances accordingly.

(Example A)

**John Dempsey Hospital**  
***Payment Contract***

:\_\_\_\_\_

:\_\_\_\_\_

:\_\_\_\_\_

Date:\_\_\_\_\_

**Re:** Patient Name:\_\_\_\_\_

**MRN:**\_\_\_\_\_

Date Of Service:\_\_\_\_\_

**Balance Due:**\_\_\_\_\_

Dear \_\_\_\_\_:

This is to confirm our conversation of \_\_\_\_\_ regarding your monthly payment.

**Your deposit of 25% is \$\_\_\_\_\_ and is due in our office by\_\_\_\_\_.**

**Your monthly installment will be \$\_\_\_\_\_ is due by the\_\_\_\_\_ of each month, beginning on\_\_\_\_\_. This contract will be reviewed every 6 months to determine if arrangement plan is appropriate.**

**Payment should be sent to:**

**John Dempsey Hospital**  
**263 Farmington Ave. Bldg #18**  
**P.O. Box 4034**  
**Farmington, Ct. 06030-4034**

In order to credit your account appropriately, please include your account(s) number on the check or money order.

If for any reason you are unable to keep this payment schedule, you must notify me immediately. Failure to do so could result in further collection action on this account.

Should you have any problems or questions, please feel free to call me directly at (860)679-\_\_\_\_\_ Monday through Friday 8:00 to 4:15 p.m.

Sincerely,

Patient Financial Services Dept.