Uncompensated Care Policies and Procedures
FY 2010 Annual Reporting

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides an update of the HHS poverty guidelines to account for last calendar year's increase in prices as measured by the Consumer Price Index.

DATES: *Effective Date:* Date of publication, unless an office administering a program using the guidelines specifies a different effective date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services (HHS), Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, state, or local office that is responsible for that program. Contact information for two frequently requested programs is given below:

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Office of the Director, Division of Facilities Compliance and Recovery, Health Resources and Services Administration, HHS, Room 10–105, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland

20857. To speak to a staff member, please call (301) 443–5656. To receive a Hill-Burton information package, call 1–800–638–0742 (for callers outside Maryland) or 1–800–492–0359 (for callers in Maryland). You also may visit *http://www.hrsa.gov/hillburton/default.htm*. The Division of Facilities Compliance and Recovery notes that as set by 42 CFR 124.505(b), the effective date of this update of the poverty guidelines for facilities obligated under the Hill-Burton Uncompensated Services Program is sixty days from the date of this publication.

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I–864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1–800–375–5283.

For information about the number of people in poverty or about the Census Bureau poverty thresholds, visit the Poverty section of the Census Bureau's Web site at *http://www.census.gov/hhes/www/poverty/poverty.html* or contact the Census Bureau's Demographic Call Center Staff at (301) 763–2422 or 1–866–758–1060 (toll-free).

For general questions about the poverty guidelines themselves, contact Gordon Fisher, Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 690–7507—or visit *http://aspe.hhs.gov/poverty/*.

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update, at least annually, the poverty guidelines, which shall be used as an eligibility criterion for the Community Services Block Grant program. The poverty guidelines also are used as an eligibility criterion by a number of other Federal programs. The *poverty guidelines* issued here are a simplified version of the *poverty thresholds* that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U). The guidelines in this 2009 notice reflect the 3.8 percent price increase between calendar years 2007 and 2008. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. The same calculation procedure was used this year as in previous years. (Note that these 2009 guidelines are roughly equal to the poverty thresholds for calendar year 2008 which the Census Bureau expects to publish in final form in August 2009.) The guideline figures shown represent annual income.

2009 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family	Poverty guideline
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than 8 persons, add $3,740 for each additional person.

2009 POVERTY GUIDELINES FOR ALASKA

Persons in family	Poverty guideline
1	$13,530
2	18,210
3	22,890
4	27,570
5	32,250
6	36,930
7	41,610
8	46,290

For families with more than 8 persons, add $4,680 for each additional person.

2009 POVERTY GUIDELINES FOR HAWAII

Persons in family	Poverty guideline
1	$12,460
2	16,760
3	21,060
4	25,360
5	29,660
6	33,960
7	38,260
8	42,560

For families with more than 8 persons, add $4,300 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines have sometimes been mistakenly referred to as the "OMB" (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as "the poverty guidelines updated periodically in the **Federal Register** by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)."

Some programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-Federally-funded activities can choose to use a percentage multiple of the guidelines such as 125 percent or 185 percent.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as "income" or "family." This is because there is considerable variation in how different programs that use the guidelines define these terms, traceable to the different laws and regulations that govern the various programs. Therefore, questions about how a particular program applies the poverty guidelines (for example, Is income before or after taxes? Should a particular type of income be counted? Should a particular person be counted in the family or household unit?) should be directed to the organization that administers the program; that organization has the responsibility for making decisions about definitions of such terms as "income" or "family" (to the extent that the definition is not already contained in legislation or regulations).

Dated: January 16, 2009.

Michael O. Leavitt,

Secretary of Health and Human Services.

[FR Doc. E9–1510 Filed 1–22–09; 8:45 am]

BILLING CODE 4151–05–P

Bad Debt Guidelines for Free Bed and RCC

Policy Account requirements prior to transfer to Bad Debt.

Impact (s) Placement of accounts in Bad Debt location.

Date October 1, 2006

Item	Policy
1	**INSURED** PATIENT, APPLICATION FOR **FREE BED** PROGRAM • Denied by hospital Free Bed does not meet the Department Health and Human Services (DHHS) income criteria (over income). Follow hospital guidelines for turn over of patient balance after insurance. The Self Pay Financial Class is (SA). • Denied by hospital Free Bed Fund does not meet eligibility criteria (dates of service prior to 10/01/2006). Follow hospital guidelines for turn over of patient balance after insurance. (SA) • Approved by hospital Free Bed Fund meets (DHHS) income criteria and is less than 100% discount. Follow hospital guidelines for turn over of patient balance after Free Bed allowance. (SA)
2	**NO INSURANCE** PATIENT, APPLICATION FOR **RCC** AND **FREE BED** PROGRAMS • Denied for RCC, the patient did not meet the definition of "uninsured patient" as defined in Connecticut General Statutes Section 19a-673(a) (4) and is over income. Denied for Free Bed Program does not meet the (DHHS) income criteria (over income). Follow hospital guidelines for turn over of patient balance. (SA) • Denied for RCC, the patient did not meet the definition of "uninsured patient" as defined in Connecticut General Statutes Section 19a-673(a) (4) and is over income. Approved for Free Bed Program does meet the (DHHS) income criteria and is less than 100% discount. Follow hospital guidelines for turn over of patient balance. (SA)

3	**UNINSURED** PATIENT, APPLICATION FOR **RCC** AND **FREE BED** PROGRAMS. • Approved for RCC (partial discount). Approved for Free Bed Program (within eligibility period) and is less than 100% discount. Follow hospital guidelines for turn over of patient balance. The Self Pay Uninsured financial class is (SU). • Approved for RCC (partial discount). Not approved for Free Bed Program (dates of service prior to 10/01/2006). Follow hospital guidelines for turn over of patient balance. (SU)

DHHS Poverty Guidelines

The Hospital of Central Connecticut NB and BM campuses

annual income:

family size	100%		90%		75%		60%		45%		30%		15%	
1	10,830	16,245	16,246	19,008	19,009	22,240	22,241	26,022	26,023	30,447	30,448	35,625	35,626	41,682
2	14,570	21,855	21,856	25,572	25,573	29,920	29,921	35,007	35,008	40,960	40,961	47,924	47,925	56,072
3	18,310	27,465	27,466	32,135	32,136	37,599	37,600	43,992	43,993	51,472	51,473	60,224	60,225	70,463
4	22,050	33,075	33,076	38,699	38,700	45,279	45,280	52,977	52,978	61,985	61,986	72,523	72,524	84,854
5	25,790	38,685	38,686	45,263	45,264	52,958	52,959	61,963	61,964	72,497	72,498	84,823	84,824	99,244
6	29,530	44,295	44,296	51,826	51,827	60,638	60,639	70,948	70,949	83,010	83,011	97,123	97,124	113,635
7	33,270	49,905	49,906	58,390	58,391	68,317	68,318	79,933	79,934	93,522	93,523	109,422	109,423	128,025
8	37,010	55,515	55,516	64,954	64,955	75,997	75,998	88,918	88,919	104,035	104,036	121,722	121,723	142,416

weekly income:

family size	100%		90%		75%		60%		45%		30%		15%	
1	208	312	313	366	367	428	429	500	501	586	587	685	686	802
2	280	420	421	492	493	575	576	673	674	788	789	922	923	1,078
3	352	528	529	618	619	723	724	846	847	990	991	1,158	1,159	1,355
4	424	636	637	744	745	871	872	1,019	1,020	1,192	1,193	1,395	1,396	1,632
5	496	744	745	870	871	1,018	1,019	1,192	1,193	1,394	1,395	1,631	1,632	1,909
6	568	852	853	997	998	1,166	1,167	1,364	1,365	1,596	1,597	1,868	1,869	2,185
7	640	960	961	1,123	1,124	1,314	1,315	1,537	1,538	1,799	1,800	2,104	2,105	2,462
8	712	1,068	1,069	1,249	1,250	1,461	1,462	1,710	1,711	2,001	2,002	2,341	2,342	2,739

* For family units with more than 8 members, add $3,740 for each additional member.

2010

The Hospital of Central Connecticut
100 Grand Street
New Britain, Connecticut 06050

RESUMEN DEL FONDO PARA HOSPITALIZACIÓN GRATUITA

Se ha creado un "Fondo para hospitalización gratuita" gracias a las donaciones en dinero o valores realizadas al Hospital of Central Connecticut para ayudar a pagar la atención de ciertos pacientes necesitados. El Fondo se utiliza para pagar el costo (total o parcial) de servicios de emergencia, ambulatorios o de internación prestados en el Hospital Central de Connecticut. Los requisitos son los siguientes:

- Haber solicitado programas de asistencia financiera dentro del estado donde reside y haber sido rechazado. **Se requiere una prueba de rechazo del Departamento de Servicios Sociales.**
- Tener un ingreso familiar igual o inferior al 250% de las Pautas Federales de Pobreza según el ingreso. **Se requiere una prueba de ingresos y/o activos.**

El Hospital Central de Connecticut proveerá una notificación de aceptación o rechazo (y el motivo) a todas las solicitudes completas para los Fondos en el plazo de dos semanas. Si se niegan los Fondos de Hospitalización Gratuita a un paciente, puede volver a pedirlos si cambia el motivo de rechazo.

Para ser elegibles para el Fondo de Hospitalización Gratuita, los solicitantes (padre o tutor, si el solicitante es menor de edad) deben:

- Presentar una identificación con fotografía, como una licencia de conducción válida de CT, pasaporte o tarjeta de identificación de inmigración (Green Card).
- Adjuntar una carta de aprobación o rechazo del Departamento de Servicios Sociales del Estado de Connecticut para recibir asistencia médica o un programa similar si no es residente de Connecticut.
- Adjuntar una prueba de ingresos y/o activos con la solicitud.

Los documentos completos deben presentarse dentro del plazo de **14 días que corresponden a la respuesta del estado o no se considerará ninguna cuenta elegible.**

Enviar por correo a:

Patient Financial Services
The Hospital of Central Connecticut
100 Grand St.
New Britain, CT 06050

ó

Entregar en:

Patient Financial Services
The Hospital of Central Connecticut
389 John Downey Drive
New Britain, CT 06051

Todas las solicitudes incompletas recibidas por el Representante Financiero de los Pacientes serán devueltas al solicitante dentro del plazo de tres semanas desde el momento de la recepción. La solicitud devuelta incluirá una carta de presentación detallada donde se indica el motivo de rechazo de la solicitud. El solicitante tendrá 30 días para presentar toda la información

requerida. Si tiene alguna pregunta con respecto a esta solicitud, no dude en comunicarse con el Representante Financiero de los Pacientes al (860) 224-5181.

The Hospital of Central Connecticut
100 Grand Street
New Britain, Connecticut 06050

OGÓLNE INFORMACJE NA TEMAT FUNDUSZU BEZPŁATNEGO ŁÓŻKA

"Fundusz bezpłatnego łóżka" został ustanowiony z datków pieniężnych i akcji przekazanych Hospital of Central Connecticut, aby pomóc zapłacić za opiekę nad potrzebującymi pacjentami. Fundusz wykorzystywany jest do opłacenia kosztów (części lub całości) usług szpitalnych, ambulatoryjnych i pogotowia ratunkowego świadczonych w Hospital of Central Connecticut. Obowiązują następujące wymagania:

- Złożenie wniosku do programów pomocy finansowej oferowanych na terenie Stanu, w którym mieszkasz i uzyskanie decyzji o niekwalifikowaniu się. **Wymagane jest Potwierdzenie odmowy z Departamentu Usług Społecznych.**

- Dochód gospodarstwa domowego musi wynosić lub być niższy niż 250% federalnej granicy ubóstwa. **Wymagane jest zaświadczenie o wysokości dochodu i/lub majątku.**

Wszystkie osoby, które złożą wypełnione wnioski, w przeciągu dwóch tygodni otrzymają od Hospital of Central Connecticut pisemne powiadomienie o pozytywnym rozpatrzeniu lub odrzuceniu wniosku (i przyczynę odrzucenia) o fundusze. Jeśli wniosek pacjenta o fundusze z Funduszu bezpłatnych łóżek zostanie odrzucony, w przypadku zmiany przyczyny, która była powodem odrzucenia pierwszego wniosku, może on być ponownie złożony.

Aby zakwalifikować się do Funduszu bezpłatnego Łóżka, wnioskodawcy (rodzice lub opiekunowie, jeśli pacjent jest osobą niepełnoletnią) muszą:

- Przedstawić dokument tożsamości ze zdjęciem, taki jak ważne prawo jazdy stanu Connecticut, paszport lub karta identyfikacyjna imigranta (Zielona karta);
- Dołączyć pismo z pozytywnym rozpatrzeniem lub odrzuceniem wniosku od Departamentu Usług Społecznych Stanu Connecticut o pomoc medyczną lub pomoc z podobnego programu, jeśli wnioskujący nie jest mieszkańcem stanu Connecticut;
- Do wniosku należy dołączyć zaświadczenie o wysokości dochodu i/lub majątku.

Wypełnione dokumenty należy odesłać w ciągu **14 dni od uzyskania odpowiedzi od stanu, bowiem w przeciwnym przypadku wszystkie spełniające warunki rachunki nie będą brane pod uwagę.**

Wysłać do: lub **Doręczyć do:**

Patient Financial Services
The Hospital of Central Connecticut
Connecticut
100 Grand St.
New Britain, CT 06050

Patient Financial Services
The Hospital of Central

389 John Downey Drive
New Britain, CT 06051

Wszystkie niepełne wnioski dostarczone do przedstawiciela pacjentów ds. finansowych zostaną zwrócone wnioskującym w ciągu trzech tygodni od dnia ich otrzymania. Zwrócone wnioski będą zawierały szczegółowe informacje, opisujące powód ich odesłania. Wnioskujący będzie miał 30 dni na przesłanie wszystkich żądanych informacji. Wszelkie pytania dotyczące wniosku należy kierować do przedstawiciela pacjentów ds. finansowych dostępnego pod numerem (860) 224-5181.

Free Bed Fund and RCC

Policy Criteria defining the purpose and use of the Free Bed Fund and RCC

Impact (s) Patient Account Receivables with self pay amounts

Date October 1, 2006

Item	Policy
1	**Free Bed Fund:** A "Free Bed Fund" has been established from gifts of money or stock donated to the hospital to help pay for the care of those with financial need. The Fund is used to pay for the cost (partially or fully) for Inpatient, Outpatient and Emergency services rendered at the hospital. The following is required: ➢ Present a photo I.D. such as a valid driver's license, passport or immigration identification card (Green Card) ➢ Patients must have applied for financial assistance programs within the State they reside and have been approved/denied eligibility. **Proof of Approval/Denial is Required.** (State Approval may not cover all dates of service in the Free Bed Eligibility period.) ➢ Patients must have a household income at or below 250% of the Federal Poverty Income Guidelines. **Proof of Income is Required.** ➢ Patients must complete a Free Bed Fund application. Free Bed Funds have maximum eligibility period of (3) three months forward. The eligibility period is determined by the date of the Free Bed application. Patients must reapply once the determined eligibility period has ended. On all completed applications, the hospital will provide a written notification of acceptance or rejection (and the reason why) for Funds within 10 business days. If a patient has been rejected for Free Bed Funds, he/she may reapply if the reason for rejection has changed.

2	**Free Bed Fund Procedure:** 1. The Admissions, Emergency, Social Services and Patient Accounts departments will have postings of Free Bed Funds availability (English, Polish and Spanish) and where to call to obtain information. 2. An informational handout describing the hospital Free Bed Funds is available in the following areas: • Admission Department • Emergency Department • Social Service Department • Patient Accounts Department This handout will be provided to the responsible party upon request or if it has been identified that the patient has exhibited financial need for assistance with their hospital accounts. 3. The Patient Accounts department will track: • Number of applications distributed • Number of applications approved and funds applied • Number of applications denied and the reason why
3	**Incomplete Free Bed Fund Applications:** All incomplete applications received by the Patient Financial Representative, will be returned to the applicant within 3 weeks of receipt. The returned application will include a detailed cover letter defining why the application was returned. The applicant will have 30 days to return all requested information. After the 30 days, accounts will be removed from guarantor follow up hold and resume collection activity.
4	**Uninsured Patients: (RCC) Public Act No. 03-266** Hospital services that have been provided to an uninsured patient (as described in Public Act No. 03-266) are eligible for a Ratio of Cost to Charge (RCC) Discount established by the Office of Health Care Access (OCHA).

5	**Non-Regulatory Adjustment:** When an application is denied for over income or the adjustment amount is less than 40%, THOCC will offer the 40% non-regulatory adjustment for all accounts within the determined eligibility period regardless of balance.
6	**Non-Paid Collection Allowance:** For all Collection Agency(s) returns for uncollectable balances, the balance will be written off using the Non-Paid Collection Allowance which will be applied to Free Bed.

The Hospital of Central Connecticut
New Britain General Campus
(860) 224-5181

The Hospital of Central Connecticut
Bradley Memorial Campus
(860) 224-5181

FREE BED FUNDS

If you are coping with a personal financial hardship, and are facing significant debts owed to The Hospital of Central Connecticut, "Free Bed Funds" may be available to cover the cost (partially or fully) for inpatient, outpatient and emergency services rendered at the hospital. The following is required:

- Applied for financial assistance programs within the State you reside and been denied eligibility. **Proof of Denial is Required.**
- Have a household income at or below 250% of the Federal Poverty Income Guidelines. **Proof of Income and/or Assets is Required.**

If you meet the above criteria, to obtain a Free Bed application please contact a Patient Financial Representative at (860) 224-5181 and include the following required documentation when returning the application (parents or guardians may complete, if the patient is a minor):

- A photo I.D. such as a valid CT driver's license, passport or immigration identification card (Green Card)
- A letter of denial from the State of Connecticut Department of Social Services for medical assistance or similar program if not a resident of Connecticut
- Proof of income and/or assets

You are entitled to reapply for Free Bed Funds if previously rejected.

FREE BED FUNDS

Jeśli borykasz się z prywatnymi trudnościami finansowymi i masz duże zadłużenie wobec szpitala Central Connecticut, koszty usług hospitalizacji, ambulatoryjnych oraz ratunkowych świadczonych przez szpital mogą zostać pokryte (całkowicie lub częściowo) z funduszu Free Bed Funds. Warunki są następujące:

- Złożenie wniosku o pomoc finansową w stanie zamieszkania i odmowa jej przyznania. **Wymagane jest świadectwo odmowy.**
- Całkowity dochód gospodarstwa domowego na poziomie 250% federalnego minimum ubóstwa lub poniżej. **Wymagane jest świadectwo dochodów i/lub majątku.**

Jeśli spełniasz te kryteria, zadzwoń do działu relacji finansowych z pacjentami pod numer (860) 224-5181, aby otrzymać wniosek o dofinansowanie z funduszu Free Bed Fund i dołącz następujące dokumenty do wypełnionego wniosku (jeśli pacjent jest niepełnoletni, mogą go za niego wypełnić rodzice lub opiekunowie):

- dowód tożsamości ze zdjęciem, jak np. prawo jazdy wydane w stanie Connecticut, paszport lub karta stałego pobytu (zielona karta);
- pisemną odmowę pokrycia kosztów leczenia przez Wydział Opieki Społecznej stanu Connecticut lub pisemną odmowę przyznania innej pomocy finansowej w przypadku zamieszkania poza stanem Connecticut;
- świadectwo dochodów i/lub majątku.

Możliwe jest ponowne składanie wniosku o dofinansowanie z funduszu Free Bed Funds w przypadku jego wcześniejszego odrzucenia.

FONDOS PARA CAMAS GRATUITAS

Si usted se encuentra enfrentando una dificultad financiera, y tiene grandes deudas con The Hospital of Central Connecticut, los "Fondos para camas gratuitas" pueden estar disponibles para cubrir (parcial o totalmente) el costo para servicios de internación, ambulatorios y de emergencia brindados en el hospital. Los siguientes requisitos son obligatorios:

- Haber solicitado programas de asistencia financiera del estado en el que reside y que estos hayan sido rechazados. **Se exige prueba del rechazo.**
- Contar con un ingreso familiar del 250% o menor del Parámetro Federal de Pobreza. **Se exigen pruebas de ingresos y bienes.**

Si cumple con los criterios mencionados, contáctese con un Representante Financiero para Pacientes para obtener una solicitud para camas gratuitas al (860) 224-5181 e incluya la siguiente documentación exigida cuando devuelva la solicitud (padres o tutores pueden completarla, si el paciente es menor de edad):

- Una identificación con foto, como una licencia de conducir vigente de CT, pasaporte o cédula de identificación inmigratoria (Tarjeta de Residencia);
- Una carta de rechazo del Departamento de Servicios Sociales del Estado de Connecticut para brindarle asistencia médica o de un programa similar si no es residente de Connecticut;
- Prueba de ingresos y bienes

Tiene derecho a solicitar nuevamente los Fondos para camas gratuitas si su solicitud ha sido rechazada previamente.

Revised 01/01/08, 01/24/2008

Bad Debt Guidelines

Overview Insures that accounts are appropriately handled for transfer to Bad Debt.

Policy Account requirements prior to transfer to Bad Debt.

Impact (s) The placement of accounts in Bad Debt location.

Seq#	Policy
1	The Pre-List Selection Report (FFR300) is produced during the last week of the month to identify all accounts eligible for transfer to Bad Debt during midnight processing on the last day of the month. Accounts are selected based on the following criteria: • Balance is patient's responsibility • Payment in full has not been received during the 3 statement cycle (approx. 90 days) • Account balance is greater than $14.99. (If the patient's responsible balance of an account is less than $15.00 and unpaid, the HBOC Star financial system will post an allowance to the account to bring the balance to $0.00. The system applies that allowance at the interval when a patient's 2nd statement would be generated and mailed for the balance due between $10.00 and $15.00. The patient does not receive a statement for a balance below $7.00.) • Account balance is less than $5,000
2	The Pre-List Selection Report is reviewed by the collection staff during the last week of the month for: • Alternative sources of payment • If patient has made 2 or more consecutive payments on the account and the criteria for a payment plan is met, the payment plan is established. • Guarantor and address are correct • Correct Bad Debt agency has been selected to process the account
3	The Pre-List Exception Report (FFR385) is produced during the last week of the month to identify all accounts eligible for transfer to Bad Debt, but have the following exceptions and will not transfer:

	• Account Balance is not completely the patient's responsibility • Account has a credit balance • Account Balance is $5,000 and greater
4	The Pre-List Exception Report is reviewed by collection staff for: • Alternative sources of payment • Potential Free Bed/Charity Care applicant • Resolution of balance transfer problems
5	Accounts with balances $5,000 or greater and do not qualify for items listed in Sequence 4, are provided to the supervisor to be approved for transfer to Bad Debt. Approval is based on the account balance: • $5,000 - $10,000 refer to Vice President of Finance • $10,001 - $25,000 refer to Chief Financial Officer • Over $25,000 refer to Chief Executive Officer After approval, the supervisor manually selects the account for transfer to Bad Debt.
6	The collection agency is responsible to provide the hospitals free bed/charity care summary with each collection notice (PA 3-266). If a patient contacts either the hospital or collection agency to apply for such funds, the collection agency is responsible to stop collection activity until notified by the hospital of the outcome of application. .
7	**Exception to sequence #1.** If a Patient's account has a statement returned by the post office with an invalid address that can not be forwarded, the account is flagged in Star to notify admitting of the incorrect address for future visits and the account is pre-listed for bad debt. The collection staff will select the mail return collection agency in Star for bad debt turnover and the account is placed in Bad Debt the last day of the month.
8	**Exception to sequence #1.** Self-pay admissions that are not collectable through standard practices are referred to an outside agency that acts on our behalf to establish Medicaid eligibility. If they are unsuccessful in establishing Medicaid eligibility and can establish payment arrangements with the patient, they retain the account. These accounts are also placed in Bad Debt on the last day of the month when referred to the outside agency.

9	**Exception to sequence #1**. Patient is expired and there is no estate or other means for payment, the account is adjusted using an uncollectable no estate adjustment.
10	**Exception to sequence #1**. If a patient is homeless or has no known address, the account is adjusted using an uncollectable adjustment.
11	**Exception to sequence #1.** If a patient is "uninsured" with an account balance greater than $10,000 and a cash asset to cover the cost of their bill. This account would be turned over to the collection agency to assist in the recovery of the balance due if attempts to collect made by Patient Accounts are unsuccessful. This turnover may occur prior to 90 days and 3 statements received.
12	**RCC Discount:** Patients who meet the definition of "uninsured" according to PA 3-266 will have their bill reduced to cost to charge. This will be done prior to turnover to Bad Debt. The collection agency will be informed that this patient is uninsured.

The Hospital of Central Connecticut
100 Grand Street
New Britain, Connecticut 06050

FREE BED FUND SUMMARY

A "Free Bed Fund" has been established from gifts of money or stock donated to The Hospital of Central Connecticut to help pay for the care of certain needy patients. The Fund is used to pay for the cost (partially or fully) for Inpatient, Outpatient and Emergency services rendered at The Hospital of Central Connecticut. The following is required:

- Applied for financial assistance programs within the State you reside and been denied eligibility. **Proof of Denial from the Department of Social Services is Required.**
- Have a household income at or below 250% of the Federal Poverty Income Guidelines. **Proof of Income and/or Assets is required.**

On all completed applications The Hospital of Central Connecticut will provide a written notification of acceptance or rejection (and the reason why) for Funds within two weeks. If a patient has been rejected for Free Bed Funds, they may reapply if the reason for rejection has changed.

To be eligible for Free Bed Fund, applicants (parents or guardians, if the patient is a minor) must:

- Present a photo I.D., such as a valid CT driver's license, passport or immigration identification card (Green Card);
- Attach letter of approval or denial from the State of Connecticut Department of Social Services for medical assistance or similar program if not a resident of Connecticut;
- Attach proof of income and/or assets with the application.

Completed documents must be returned within **14 days of state response or all eligible accounts may not be considered.**

Mail to:

Patient Financial Services
The Hospital of Central Connecticut
100 Grand St.
New Britain, CT 06050

or

Deliver to:

Patient Financial Services
The Hospital of Central Connecticut
389 John Downey Drive
New Britain, CT 06051

All incomplete applications received by the Patient Financial Representative, will be returned to the applicant within three weeks of receipt. The returned application will include a detailed cover letter defining why the application was returned. The applicant will have 30 days to return all requested information. If you should have any questions in regards to this application, please don't hesitate to contact a Patient Financial Representative at (860) 224-5181.

Revised 01/01/08, 01/23/08, 04/22/09

THE HOSPITAL OF CENTRAL CONNECTICUT
New Britain, Connecticut

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name: _____ Date of application: _____

Address: _____ Medical Record #: _____

_____ HCC Rep. Int.: _____

Applied for Financial Assistance with programs within the State you reside for medical assistance (Yes/No) _____

If *YES*, please include copy of the denial letter.

If *NO*, as mentioned on page one, we cannot process your Free Bed application unless you have completed the application process for medical assistance within the State you reside and have been denied coverage.

Please list any health insurance or accident coverage (liability, auto or workers compensation) that you have, which may cover your outstanding balances:

Insurance Company name: _____

ID/Policy number: _____

Insurance Telephone Number: _____

I understand it is my responsibility to provide all requested information to assist The Hospital of Central Connecticut in making an eligibility determination.

_____ _____

Patient Signature or Authorized Agent Date

PATIENT NAME

NAME: _____ DATE OF BIRTH: _____

GUARANTOR INFORMATION

RELATIONSHIP TO PATIENT: ( ) SELF ( ) PARENT

NAME: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ WORK PHONE #: _____

MARITAL STATUS: _____ # DEPENDENTS: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

_____

INCOME (PLEASE NOTE WEEKLY/ MONTHLY/ ANNUALLY)

GROSS SALARY: _____

SOCIAL SECURITY INCOME: _____ CHILD SUPPORT: _____

SOC SEC DISABILITY: _____ ALIMONY: _____

PENSION: _____ STOCKS / BONDS _____

WORKERS COMP: _____ UNEMPLOYMENT: _____

RENTAL PROPERTY INCOME: _____ PUBLIC ASSISTANCE/ FOOD STAMPS: _____

TRUST: _____

OTHER (type & source): _____

PARENT OF PATIENT IF PATIENT IS A MINOR, OR PATIENT'S SPOUSE

NAME: _____

DATE OF BIRTH: _____ WORK PHONE #: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

INCOME (PLEASE NOTE WEEKLY/ MONTHLY/ ANNUALLY)

GROSS SALARY: _____

SOCIAL SECURITY INCOME: _____ CHILD SUPPORT: _____

SOC SEC DISABILITY: _____ ALIMONY: _____

PENSION: _____ STOCKS / BONDS _____

WORKERS COMP: _____ UNEMPLOYMENT: _____

RENTAL PROPERTY INCOME: _____ PUBLIC ASSISTANCE/ FOOD STAMPS: _____

TRUST: _____

OTHER (type & source): _____

DEPENDENT INFORMATION IF UNDER 18

CHILD'S NAME	SS#	DATE OF BIRTH	INCOME (type & source)	CHILD LIVES WITH WHOM

SAVINGS and ASSETS

SAVINGS ACCOUNT BALANCE: _____ CHECKING ACCOUNT BALANCE: _____

RETIREMENT ACCOUNT (IRA): _____

403B/ 401K: _____

ANNUITY: _____

TRUST: _____

OTHER: _____

MONTHLY EXPENSES

RENT AMOUNT: _____

MORTGAGE AMOUNT: _____

I certify that the information provided is true. I also authorize The Hospital of Central Connecticut and/or its agents to investigate the references and statements or other data obtained from me or from any other person pertaining to my credit and financial responsibility.

Date of Signing: _____

By: _____
(Patient or Authorized Agent)

_____
(Relationship to Patient)

Witness: _____

If someone helped the applicant complete this form, this person must sign also.

_____

Helper's Signature | Relationship (if any) | Date

Financial Assistance for Non-Regulatory Patients

Overview Hospital guidelines for Non-Regulatory Patients that do not want to go through the application process for our Free Bed/Reduced Care Program.

Impact (s) Receivables

Item	Policy
1	Financial Assistance is available for all non-regulatory patients that choose not to go through the application process for Free Bed/Reduced Care, as in the "Public Act No. 03-266". The Patient Accounts representative will discuss payment options if a patient contacts the hospital and requests assistance on their account(s). The Patient Accounts representative will review the patient's outstanding self-pay balances. The agreed upon financial assistance will automatically be applied to the eligible individual account(s). The Patient Accounts representative will change the statement cycle back to level one. If the discounted balance is not paid within three statement cycles, the account will follow the collection process.
2	Financial Assistance Guidelines: The Financial Assistance for Non-Regulatory Patients will be offered to all patients with **individual** or **combined** account balances $100.00 and over who contact the hospital to request assistance or patients that have been identified as needing assistance, and choose not to go through the application process as in the "Public Act No. 03-266".

Patient Payment Arrangements

Policy Criteria defining Patient Payment Arrangements for patient's accounts.

Impact (s) Patient Account Receivables

Item	Policy
1	**Patient Payment Guidelines:** The guidelines below define the amount and term that NBGH and BMH can accept as a payment plan from the patient. The balance range is for all accounts owed by the patient not at a collection agency. Balance Range: / Term: $10.00-$249.99 / No Arrangements $250.00-$500.00 / 6 Months $500.01-$2400.00 / 12 Months $2400.01< / 12 – 24 Months w/ Mgmt. Approval
2	**Canceling a Patient Payment Plan:** If the patient misses an installment of their payment plan and can not make the payment up in the next month's statement, the payment plan will be cancelled and the patient is responsible for payment in full to avoid turnover to a collection agency.
3	**Patient Unable to make Payment Plan per Policy:** When patient/guarantor contacts the customer service department and informs them of being unable to make payment on their accounts per policy guidelines, we are responsible to inform the patient of potential state and hospital assistance available to cover the cost (partially or fully) for Inpatient, Outpatient and Emergency Services rendered at the hospital. (Refer to Free Bed Policy or Summary for detail requirements)