Western Connecticut Health Network
FINANCIAL POLICY
CREDIT AND COLLECTION

I. GENERAL

A. Confirmation of Payment Source. To ensure adequate reimbursement to meet operating needs, WCHN (the "Western Connecticut Health Network") requires payment or proof of the ability to pay at or before the time of service. Consistent with its charitable mission, however, the Network will not deny medically necessary care because of a lack of financial information or financial resources. The Network may delay or deny elective care if financial resources are not properly identified.

B. Referral for Collection. In general, it is the Network's policy that accounts not paid within ninety (90) days will be reviewed for appropriate collection action. However, no account will be sent to collection until reasonable efforts have been undertaken to determine whether the patient is eligible for free or discounted care pursuant to the Network's Financial Assistance Policy.

C. Write-Off of Uncollectible Accounts. No later than sixty (60) days after review, accounts deemed uncollectible will be written-off.

D. Terminology. For purposes of this Policy, the term "patient" is used with regard to the patient or the applicable payment source for the patient's care (*e.g.*, parent, guardian or other responsible party).

II. ASSIGNMENT OF BENEFITS

A. Medicare – With proper identification, the Network will accept Medicare assignment for covered services. Deductibles and co-pays are due in accordance with federal regulations. Non-covered services, with proper notification, are payable at the time of service or billing. The Network recognizes its responsibility to provide notice of non-coverage.

B. Contracted Payors (*e.g.*, Blue Cross) – With proper identification, the Network will accept payor assignment for covered services. Deductibles and co-pays are due in accordance with the relevant payor agreement then in force. Non-covered services, with proper notification, are payable at the time of service or billing. The Network recognizes its responsibility to provide notice of non-coverage.

C. Medicaid – With proper identification, the Network will accept Medicaid assignment for covered services.

D. Other Third-Party Coverage – With proper identification, the Network will, as a courtesy, bill other non-contracted third-party payors. Since the Network does not have a contractual relationship with these payors, the Network considers the patient ultimately responsible for payment. The Network will wait a maximum of

sixty (60) days from initial billing for third-party payment; thereafter, any outstanding balance immediately becomes a patient responsibility. After one hundred twenty (120) days, all outstanding balances are immediately due from the patient. The Network may, in its discretion, wait another thirty (30) days if the patient and/or third-party payor shows a good faith effort to expedite payment.

E. Self-Pay Obligations – As noted above, the Network will not deny necessary care because of a lack of financial resources. However, self-pay obligations are payable at the time of service or billing. The Network will assist a patient in obtaining available third-party coverage. Additionally, the Network will provide a credit review to determine if extended credit terms are warranted. In all cases, self-pay patients will be informed of the availability of free or discounted care pursuant to the Network's Financial Assistance Policy. In connection with its services to uninsured patients, the Network will at all times abide by applicable provisions of federal and state law, including without limitation as set forth in the Network's Financial Assistance Policy.

III. DELAY/DENIAL OF CARE

A. Conditions for Delay/Denial of Care. The Network will not delay or deny medically necessary care because of a lack of financial information or financial resources. However, the Network may delay or deny elective care if financial resources are not properly identified.

1. Inpatient and One Day Surgical Admissions – The patient, admitting physician, chief of service and the operating room (if necessary) will be notified as soon as possible of any admission delayed or denied for financial reasons.

2. Outpatient – The patient, the department requested to provide service, and the referring physician will be notified as soon as possible of any treatment or services delayed or denied for financial reasons.

B. Determination of Medical Necessity. Issues regarding determination of medical necessity will be resolved between the attending (referring) physician and the chief of service.

IV. ADMINISTRATION OF POLICY

The Network's Business Office will administer and implement this Policy and will assume the following responsibilities:

A. Undertaking credit analysis to assess patients' ability to pay;

B. Ensuring that patients are aware of the availability of free or discounted care pursuant to the Network's Financial Assistance Policy and, as appropriate, assisting patients in preparing the appropriate application and supporting materials;

C. Providing additional guidance and assistance to patients through trained financial counselors;

D. Collaboratively working with patients to establish payment arrangements that are fair, equitable, and realistic in light of each patient's available financial resources;

E. Following up with patients or payors regarding the status of delayed or delinquent payments;

F. Recommending write-offs for accounts deemed to be uncollectible;

G. Recommending referrals to outside collection agencies, where appropriate; and

H. Recommending collection litigation in appropriate circumstances, after consultation with the Network's legal counsel.

V. COLLECTION

A. Measures Prior to Collection Agency Referral. Prior to referring any patient account to an external collection agency or initiating any legal action against an individual patient (or the patient's estate), the Network will take reasonable measures to confirm both of the following:

1. That no alternative payment sources exist (whether through insurance, governmental programs, or family or other parties having legal responsibility for payment), or that all alternative payment sources have been exhausted; and

2. That the Network has provided the patient with at least three (3) separate written communications specifically stating the following:

   - Whether the Network deems the patient an insured patient or uninsured patient, and the reasons for each such determination;

   - That the patient may qualify for free or discounted care pursuant to the Network's Financial Assistance Policy, with reasonable instructions regarding the process for applying thereunder; and

   - That the Network is willing to work with the patient in establishing payment arrangements that are fair, equitable and realistic in light of the patient's available financial resources.

B. Permissible Collection Agencies. The Network may refer patient accounts to one or more established, reputable debt collection agencies, provided that each such agency has provided the Network with written confirmation that such agency:

1. Will utilize only those collection techniques specifically permitted by the Network, whether pursuant to this Policy or otherwise;

2. Will not utilize any collection techniques specifically prohibited by the Network pursuant to this Policy; and

3. Will otherwise abide by applicable federal and state law.

The Network will not refer any patient account to a collection agency that has failed to provide the foregoing written confirmation. In addition, the Network will immediately terminate its relationship with any agency that has provided such a confirmation but fails to adhere thereto.

C. Collection Techniques.

1. Network to Specify. The Network will specifically instruct (whether by providing a copy of this Policy or otherwise) every collection agency it retains regarding debt collection techniques that are expressly permitted, and those that are expressly prohibited, in pursuing collection of patient accounts on behalf of the Network.

2. Permitted Collection Techniques. Permitted collection techniques include:

- Telephone calls
- Written correspondence
- Skip tracing
- Wage garnishment
- Liens on assets (including but not limited to primary residences) *[consider refraining from primary residence]*
- Small claims or other legal actions
- Other techniques permitted by law and not expressly prohibited below

3. Required Written Statements. In at least two of its written communications with patients, the agency must specifically state the following:

- Whether the Network deems the patient an insured patient or uninsured patient, and the reasons for each such determination;

- That the patient may qualify for free or discounted care pursuant to the Network's Financial Assistance Policy, with reasonable instructions regarding the process for applying thereunder; and

- That the Network is willing to work with the patient in establishing payment arrangements that are fair, equitable and realistic in light of the patient's available financial resources.

4. Prohibited Collection Techniques. A collection agency working on behalf of the Network may not do any of the following:

- Harass, oppress or abuse any person;
- Threaten to have the patient arrested for non-payment of debts;
- Falsely imply that they are attorneys or government representatives;
- Falsely imply that the patient has committed a crime;
- Falsely state that they operate or work for a credit bureau;
- Misstate the amount of the patient's debt;
- Misrepresent the involvement of an attorney in connection with collecting amounts owed;
- Indicate (i) that papers being sent are legal forms when they are not, or (ii) that papers being sent are not legal forms when they are;
- Threaten any collection action or measure not permitted by law;
- Provide false credit information about the patient to a third party;
- Use a false name; or
- Use any other collection methods prohibited by law.

Updated: 10/01/12

CH01/ 25575066.3

WESTERN CONNECTICUT HEALTH NETWORK

DANBURY HOSPITAL · NEW MILFORD HOSPITAL

DOCUMENT INFORMATION:

Subject: **Patient Financial Services – *Financial Assistance Policy***

PURPOSE:

A. WCHN is committed to advancing the health and well-being of those in its community by providing an integrated high quality and cost effective network of health care services and education centered around a teaching hospital, consistent with current medical standards for the prevention, diagnosis, treatment, and rehabilitation of illness; and anticipating and responding to new developments in the health care system; and integrating its services with those of other medical and social service organizations in the region (e.g., home health care agencies, long term care facilities, and physical, mental, alcohol, and drug rehabilitation) so as to optimize the availability of such services within the region in a cost effective manner. Consistent with this mission, WCHN recognizes its obligation to the community it serves to provide financial assistance to indigent persons within the community.

B. In furtherance of its charitable mission, WCHN will provide both (i) emergency treatment to any person requiring such care; and (ii) essential, *non-emergent* care to patients who are permanent residents of its primary service area who meet the conditions and criteria set forth in this Policy, without regard to the patients' ability to pay for such care. Elective procedures generally will not be considered essential, non-emergent care and usually will not be eligible for Financial Assistance.

POLICY:

A. Western Connecticut Health Network, Inc. ("WCHN") and its affiliates are not for profit, tax-exempt entities with a charitable mission of providing medically necessary health care services to residents in its defined service area, regardless of their financial status and ability to pay.

B. It is the policy of WCHN to provide "Financial Assistance" (either free care or reduced patient obligations) to persons or families where: (i) there is limited or no health insurance available; (ii) the patient fails to qualify for governmental assistance (for example Medicare or Medicaid); (iii) the patient cooperates with the Hospital in providing the requested information; (iv) the patient demonstrates financial need; and (v) WCHN makes an administrative determination that Financial Assistance is appropriate.

C. After the Hospital determines that a patient is eligible for Financial Assistance, the Hospital will determine the amount of Financial Assistance available to the patient by utilizing the Charitable Assistance Guidelines (**Exhibit 1**), which are based upon the most recent Federal Poverty Guidelines issued by the U.S. Department of Health and Human Services ("FPGs").

D. In the case of patients who qualify for discounted (but not free) care, the Hospital will work in good faith with patients to establish payment plans that are fair and workable in light of each patient's available resources.

E. WCHN will regularly review this Financial Assistance Policy to ensure that at all times it: (i) reflects the philosophy and mission of the Hospital; (ii) explains the decision processes of who may be eligible for Financial Assistance and in what amounts; and (iii) complies with all applicable state and federal laws, rules, and regulations concerning the provision of financial assistance to indigent patients. In the event that applicable laws, rules or regulations are changed, supplemented or clarified through interpretative guidance, the Hospital will modify this Policy and its practices accordingly.

PROCEDURE:

ELIGIBILITY AND DETERMINATION OF AMOUNT

A. Eligibility: A patient will be eligible for Financial Assistance if the patient: (i) has limited or no health insurance; (ii) applies for but is deemed ineligible for governmental assistance (for example Medicare, Medicaid or State-Administered General Assistance); (iii) cooperates with the Hospital in providing the requested information; and (iv) demonstrates "financial need" or is deceased with no estate, no payment source and no health insurance. In addition, a patient will be eligible for Financial Assistance in the event WCHN administration, in its discretion, deems such eligibility appropriate under a patient's unique circumstances (for example, where a patient has insurance coverage but lacks the financial resources to pay applicable co-pays, deductibles and excess amounts). For purposes of this Policy, the term "patient" is used with regard to the patient or the applicable payment source for the patient's care (*e.g.*, parent, guardian or other responsible party).

B. Financial Need: A patient may be deemed to have financial need: based on either **indigency/financial hardship** or **medical hardship** (each as defined below).

1. Indigency/Financial Hardship: A patient may demonstrate financial hardship by showing that the patient has **income** and **available assets** below the FPG thresholds set forth on **Exhibit 1** (as amended from time to time to reflect the most current FPGs published by DHHS). For these purposes, "income" includes salaries, legal judgments, unemployment compensation, dividends, interest checks and other recurrent sources of income or resources. "Available assets" includes savings, certificates of deposit, individual retirement accounts, marketable securities or similar liquid assets readily convertible to cash (however, in no event will this term include a patient's primary residence). *[Note: Consider whether to leave assets out of the eligibility determination, and factor into the analysis of an appropriate payment plan for the remaining balance owed.]*

   If a patient's income and available assets combined are at or below **600%** of the FPGs, the patient will receive some form of Financial Assistance. The Financial Assistance may be either a complete waiver of all patient responsibility or a discount or reduced patient obligation, depending on the patient's income.

   - If a patient's income and available assets combined fall between **0%** and **400%** of the FPGs, the patient will have no financial responsibility for the care provided by the Hospital. This means that the full charges for services rendered (including copayment and deductible amounts) are completely waived.

   - If a patient's income and available assets combined are greater than **400%** of the FPGs but not more than **500%** of the FPGs, the patient will qualify for a 50% discount on the charges for services rendered.

   - If a patient's income and available assets combined are greater than **500%** of the FPGs but not more than **600%** of the FPGs, the patient will qualify for a 30% discount on the charges for services rendered.

2. Medical Hardship: In addition to income and assets, WCHN will also consider Financial Assistance where a patient's medical bills are of such an amount that payment threatens the patient's financial survival. In such circumstances, the discount to be offered to the patient will be determined by Hospital personnel in their discretion.

C. Calculation of Amounts to Be Billed: The net amount to be billed to a patient qualifying for financial assistance hereunder will be determined by (i) calculating the gross charges for services rendered to the patient, and (ii) applying the appropriate discount (as determined pursuant to the above and Exhibit 1). Notwithstanding the foregoing, however:

1. Consistent with Connecticut law, any uninsured patient whose income (alone, without regard to available assets) falls below **250**% of the FPGs will not be charged more than WCHN's cost of providing services to the patient; and

2. Consistent with applicable Federal tax laws, the net amount billed to any patient qualifying for financial assistance pursuant to this Policy (after applying the appropriate financial assistance discount determined above) will not exceed the greater of (i) the net amount that would be charged based on applying an average of the Hospital's three highest commercial payor discounts, or (ii) Medicare rates.

[Note: The provisions of 501(r) are subject to multiple interpretations. The language proposed here is the more favorable interpretation for hospitals. Depending on how these issues evolve through the development of regulations and interpretative guidance, however, we may need to switch to the more patient-friendly approach, whereby the charge limitation is applied at the gross charge level, before the financial assistance discount is applied.]

COMMUNICATION

The Hospital will communicate the availability of Financial Assistance to its patients and the general public through measures that include providing or posting copies of this Policy, summaries thereof (if more conducive to patient understanding), appropriate signage and/or brochures:

- On the Hospital's website;
- In the Hospital's Emergency Department;
- In the Patient Registration and Admissions areas;
- In the Patient Financial Services Department;
- In other waiting areas throughout the Hospital premises (as may be reasonably workable and appropriate);
- In patient informational binders included in patient rooms; and
- In bills and statements sent to patients.

As provided above, Patient Registration staff and Patient Financial Counselors will ensure that all self-pay patients are notified regarding the availability of Financial Assistance per the terms of this Policy.

Pertinent materials will be provided in English, Portuguese, and Spanish, which are the languages appropriate to the community served by the Hospital. All such materials will include pertinent contact telephone numbers and/or e-mail addresses to permit patients appropriate resources for completion of the Worksheet and answers to any other questions they may have about the Hospital's Financial Assistance Program.

DOCUMENTATION AND RECORDKEEPING

A. The Financial Services Department will maintain all documentation of Financial Assistance within the Hospital's Financial Assistance file. The Financial Assistance file will include a cumulative total of Financial Assistance cases, together with supportive documentation. Supportive documentation will include, at a minimum, the following:

- The number of applicants for free and reduced cost services;

- The number of approved applicants;
- The total and average charges and costs of the amount of free and reduced cost care provided;
- Any other information required by, or necessarily to permit complete and accurate reporting under, applicable federal and state laws (including without limitation CT Public Act 03-266).

B. The Vice President of the Revenue Cycle will review the status of the Financial Assistance program with the Chief Executive Officer, or his/her designee, on a regular basis. The Chief Executive Officer or his/her designee will be responsible for presenting this Financial Assistance Policy to the Board of Directors at least annually. Such presentation will include a detailed statement on what the Hospital's policy is on Financial Assistance, the impact of this Financial Assistance Policy on Hospital operations and the level of need and benefits being conferred to the community under the Hospital's Financial Assistance program.

C. Information about the amount of Financial Assistance provided will be provided in accordance with federal and state laws and regulations on reporting information under the Hospital's Financial Assistance Policy.

PATIENT RIGHTS AND RESPONSIBILITIES

A. To be eligible for Financial Assistance, the patient must cooperate with the Hospital by providing the necessary information and documentation necessary to apply for appropriate federal and state governmental assistance and other financial resources that may be available to pay for his/her health care. Prior to being considered eligible for Financial Assistance from WCHN, the patient must apply for all other appropriate sources of financial assistance. WCHN will assist patients with making such applications by providing assistance in completing the relevant forms and by assisting the patient with understanding how his/her income and assets relate to the Hospital's Charitable Assistance Guidelines. Consistent with this Policy, where the Hospital is aware that a patient will not qualify for a particular type of federal or state governmental assistance (e.g., based upon citizenship), the Hospital may waive the requirement that the patient apply for such assistance prior to becoming eligible for Financial Assistance.

B. Any request for Financial Assistance will be made by or on behalf of a patient. Patients may apply for, and will be encouraged to apply for, Financial Assistance before, during or within a reasonable time after Hospital care is provided. In the event a patient does not initially qualify for any Financial Assistance, the patient may re-apply upon a showing of change in circumstances.

C. Patients who are deemed eligible for any Financial Assistance must: (i) cooperate with the Hospital to establish a reasonable payment plan, which will take into account all available income and assets, the amount of the discounted bill and any prior payments; and (ii) make good faith efforts to honor any agreed-to payment plan for their discounted Hospital bills. Patients who fail to make payments according to their established payment plans will be contacted by the Hospital by telephone and in writing to address the circumstances; in such cases, Hospital Financial Counselors will work with patients to establish a modified payment plan suitable to the patient's needs and resources. However, if a patient refuses contact from the Hospital or otherwise fails to respond after repeated efforts by the Hospital over a reasonable time period, the Hospital may submit a patient's account to collection. In that context, collection measures may include garnishment, liens (including on residences) and other practices consistent with applicable law.

D. Patients are responsible for communicating to the Hospital any change in financial status that may adversely impact their ability to pay their discounted Hospital bill or to honor the provisions of their payment plans. Similarly, in the event that a patient's financial circumstances become more favorable while receiving assistance under the Hospital's Financial Assistance program, the patient will be required to notify the Hospital of such change in circumstances.

E. All self-pay patients will be informed of the availability of financial assistance pursuant to this Policy.

F. Because a patient is not eligible under this Policy until s/he has applied for and been deemed ineligible for federal and state governmental assistance programs, WCHN's Financial Services Department will assist patients in enrolling in federal and state governmental assistance programs. Trained financial counselors and other personnel may be contacted at (203) 739-7773 or (203) 730-5800 for any assistance required in completing the Application for Financial Assistance or with any other materials required by the Hospital under this Policy.

G. Although ideally the Hospital will make a determination about Financial Assistance during pre-registration or prior to discharge, this may not be possible, either because the patient does not provide the necessary documentation, or the patient's circumstances change after discharge, or in other circumstances where a given patient's circumstances or needs are identified. **A patient may request consideration at any time, and WCHN will evaluate a patient's eligibility under this Policy as requested, up to and including consideration during the collections and judgment phase.** Patients are encouraged to contact the Hospital if their circumstances change or if additional need is identified. The Hospital will review all information provided and relevant circumstances bearing on the need for Financial Assistance, will make a determination of eligibility, and will promptly notify the patient of his/her financial obligations, if any, as set forth below.

H. Eligibility Determination Procedure

1. Hospital staff will immediately forward to the Hospital's financial counselors a copy of the pre-admission record for any patient who has no insurance. Financial counselors will contact the patient to schedule a financial interview as soon as is practicable but ideally before admission for a non-emergent, medically necessary service, and prior to discharge for an emergency admission. For emergency services, the Hospital will not delay screening or treatment of an emergency medical condition pending this financial interview.

2. To determine whether a patient is eligible for Financial Assistance, the patient will be required to complete the Patient Financial Worksheet (**Exhibit 2**). The Worksheet will be made readily available to patients through methods including (without limitation) posting on the Hospital's website, distribution at the Hospital's Patient Registration and Admissions areas and the Patient Financial Services offices, and inclusion in the informational binders provided in patient rooms.

3. Patients must return the Worksheet to the financial counselor in the self-addressed stamped envelope provided by the Hospital within ten (10) days. Failure to timely supply required information will result in denial of a patient's request for provision of Financial Assistance. Patients are obligated to cooperate and provide all information needed in a timely manner. The Hospital will make reasonable efforts to offer and provide assistance to patients in connection with the completion of the Worksheet. However, if assistance is needed in gathering necessary information or materials requested as part of the Financial Assistance qualifying process, patients are encouraged to contact one of the Hospital's trained financial counselors at (203) 739-7773 or (203) 730-5800. Financial counselors also are available to assist patients with assessing their financial situations, gathering information requested by the Hospital, and assisting with similar tasks.

4. As part of the financial interview process, financial counselors will request the following documentation in order to process and validate Financial Assistance applications:

   a. Confirmation of annual income and assets:

      - Last four pay stubs and/or W2 form, social security award, unemployment compensation letter

- Most recent income tax return
- Most recent checking and savings account statements for all accounts upon which patient is listed as an account-holder
- Banking/investment account statements

b. Confirmation of patient's Social Security Number and birth date. Proof must be in the form of one of the following:

- Social Security Card
- Birth certificate
- Baptismal Certificate
- Military Discharge Papers
- School Records
- Drivers License

c. Confirmation of residence in the form of one or more of the following:

- Mortgage Book
- Current Rent Receipt
- Current Lease
- Tax Bill
- Room and Board Statement
- Utility Bill
- Written Verification from Landlord

I. Although the information above is required from patients seeking Financial Assistance, the Hospital in its discretion may choose not to require some or all documentation depending upon circumstances and the patient's ability to obtain documentation.

J. Patients have an obligation to provide information reasonably requested by the Hospital so that the Hospital can make a determination of a patient's eligibility for Financial Assistance. **If a patient claims s/he has no means to pay but fails to provide the information reasonably requested by the Hospital, there will be no Financial Assistance extended and normal collection efforts may be pursued in the Hospital's sole discretion.**

K. Eligibility and Notification Process:

1. Upon receipt of a patient's Patient Financial Worksheet, the Financial Services Department will review the patient's application to determine that it is complete, including all required documentation. If it is not complete, the application will be returned to the patient for completion. If the Hospital returns an application to a patient as incomplete, the Hospital will contact that patient by telephone. If the Hospital is able to reach the patient by telephone, the Hospital will offer the patient an in-person or telephonic interview to determine such patient's eligibility for Financial Assistance. If the Hospital is unable to reach the patient by telephone, or if there is no listed telephone number available, the Hospital will send a letter to the patient that details what is needed and that explains to the patient that it is his/her responsibility to contact the Hospital within ten (10) days of receiving the letter. The Hospital's trained financial counselors will offer to meet with the patient to assist him/her in completing the application so that the Hospital has all of the necessary information to make a determination on the patient's eligibility for Financial Assistance.

2. The Financial Services Department will complete the Financial Assistance Eligibility Determination Form attached as **Exhibit 3**, and will determine the amount the patient owes, if any. The Financial Services Department will inform the patient of his/her eligibility for Financial Assistance, and the amount of such Financial Assistance, within five (5) business days of the determination.

3. A determination of eligibility under this Policy will be effective for one (1) year. At the end of such time period, patients continuing to require essential medical services will be expected to re-apply or update their prior applications, in order to permit the Hospital to make a new determination regarding the patient's continuing eligibility for Financial Assistance.

EXHIBIT 1

FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES
Based on 2012 Federal Poverty Guidelines

Family Size	Federal Poverty Guidelines (2012)	250% - 400 % (or Below) Poverty Guidelines *(100% write-off)*	400% - 500% Poverty Guidelines *(50% write-off)*	500% to 600% Poverty Guidelines *(30% write-off)*
1	$11,170	$27,925 to $44,680	$44,681 to $55,850	$55,851 to $67,020
2	$15,130	$37,825 to $60,520	$60,521 to $75,650	$75,651 to $90,780
3	$19,090	$47,725 to $76,360	$76,361 to $95,450	$95,451 to $114,540
4	$23,050	$57,625 to $92,200	$92,201 to $115,250	$115,251 to $138,300
5	$27,010	$67,525 to $108,040	$108,041 to $135,050	$135,051 to $162,060
6	$30,970	$77,425 to $123,880	$123,881 to $154,850	$154,850to $185,820
7	$34,930	$87,325 to $139,720	$139,721 to $174,650	$174,651 to $209,580

** For family units with more than 8 members, add $3,960 for each additional member.

Note: This Exhibit shall be updated from time to time to reflect the most current FPGs issued by the U.S. Department of Health and Human Services.

EXHIBIT 2

PATIENT/PAYMENT SOURCE FINANCIAL WORKSHEET

Patient Name:_____ Account Number:_____
Household Size:_____

1A Calculation of Available Income
Monthly Salary/Pension _____ x 12 _____
Monthly SSI/VA _____ x 12 _____
Income Total _____ x 12 _____ (AA)

1B Calculation of Monthly Expenses
Rent _____
Electric _____
Gas _____
Telephone _____
Water _____
Car Payments _____
Credit Cards _____
Insurance _____
Other _____ _____
Food ($100.00 x dependents) _____
Monthly Expense Total _____
Expense Total _____x 12_____(BB)

1C Eligible Income for Hospital Bills _____ (CC)
(AA – BB) (if less then 0, enter 1)

1D Estimate Hospital Billing to Patient _____ (DD)

1E Identification of Liquid Assets
Bank Accounts _____
Bonds _____
Stocks _____
CD's _____
Mutual Funds _____
Liquid Asset Total _____(EE)

1F Total Patient Due Minus Liquid Assets (DD- EE) _____(FF)

1G Eligible Income Minus Patient Due (CC-FF) _____(GG)
Note: If GG is a negative number, then patient will have no financial responsibility.

_____
_____ I attest that the above information is correct.

_____ I attest that the Patient/Payment Source is unemployed and cannot provide employment documentation.

_____ _____
Signature of Patient/Payment Source Date

EXHIBIT 3

FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION FORM

Date: _____

WCHN has conducted an eligibility determination for Financial Assistance for:

Name: _____

Medical Record Number: _____

The completed request for Financial Assistance was submitted by the patient or on behalf of the patient on: _____

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made.

_____ Your request for Financial Assistance has been denied because your income and available assets exceed those set forth in WCHN's Financial Assistance Guidelines.

_____ Your request for Financial Assistance has been approved for services rendered on _____. The entire balance will be treated as free care.

_____ Your request for Financial Assistance has been approved in accordance with the criteria under P.A. 03-266 for services rendered on _____.

_____ You qualify for a discount on charges consistent with the Hospital's sliding scale. This office will contact you to establish a payment plan.

_____ Your request has been denied for the following reason:

_____

_____

_____ Other (please described in detail):

_____

_____

If you have questions about this determination, please contact:
_____ at (203) _____, extension _____.

Originator (Department):
Original Date: 5/1/1997
Revision Date: 9/26/12
Review Date: 2/ /13
Regulatory Agency/Agencies & Ref Number(s):
Replaced Policy & Procedure (if applicable):
Committee Approvals & Dates:
Department Head Approval:
Administrative Approval & Date: **EXECUTIVE LEADER**

These policies and procedures are for the use of Western Connecticut Health Network (WCHN) and are not to be disseminated to any other organization without the prior written approval from the above signed Administrator.

SELF-PAY COLLECTION PROCESS

Pure Self-Pay (F/C P) Inpatient and Outpatient Accounts

Timeline:

One day after blue & white bill, system sends Letter 94 "uninsured letter" to guarantor (OP) and Letter 95 "uninsured letter" to inpatients.

Fifteen days (IP) or thirty days (OP) from the first blue and white bill, patient balance > $24.99, system sends statement to guarantor.

Thirty days from last statement, patient balance between $25.00 and $2499.99, system sends final notice letter to guarantor. (For account balances > $2499.00 collector follows up manually)

Thirty days from final notice letter, patient balance between $25.00 and $2499.99, system changes financial class to Z, which is pre bad debt (Sits in Z for 3 weeks then changes to FC G).

- **Charges are reviewed for accuracy.**

- **All accounts are reviewed by entering Medical Record Number into the patient accounting system. Each account is assessed for insurance information or programs available through Danbury Hospital or outside agencies such as charity, grants, eligibility under Public Act 03-266, or Medicaid. If insurance information is found, the status is reviewed for payment or denial. If denied, the reason for denial is identified and the account is assessed for potential resubmission. All notes on other accounts are reviewed for any information that may be helpful in the collection of all outstanding accounts.**

- **If no insurance information is identified, an inpatient final bill is mailed to the guarantor with a letter and a copy of the summary letter detailing charity policies and the qualifications for P.A. 03-266 (see attached). Outpatient bills are sent without a letter, however the summary letter detailing charity policies and qualifications for P.A. 03-266 is sent separately.**

- **The guarantor is contacted for payment in full, settlement in full, or time payments. If the guarantor indicates they are unable to pay or cannot meet Danbury Hospital's time payment policy, the guarantor is referred to the Financial Counselor for assessment for other programs, i.e. Medicaid, charity, P.A. 03-266. If the account balances for the outstanding accounts are less than $500.00 each, the account is reviewed for small balance charity. For all inpatient and outpatient surgery accounts the financial counselor's**

notes are reviewed. If there are no notes from the financial counselor, the supervisor in financial counseling is contacted for review.

- All self-pay inpatient and outpatient surgery accounts with account balance over $2,499.99 are reviewed by the collection team. The financial counselor should have worked these accounts and documented their assessment. All accounts identified for Atty Simko by the financial counselor are referred to Attorney Simko by the Collection Team after review with the Managers of Patient Access and Patient Financial Services.

- If the guarantor cannot be reached at home or if there is no home telephone available, the place of employment is contacted if applicable. If guarantor cannot be reached at employment or is unemployed, an attempt is made to contact all "Emergency Contacts" identified in Patient Management.

- If a message is left for the guarantor, a follow-up call is made within 48 hours.

- A contact letter is mailed for all accounts where the collector has been unsuccessful in reaching the guarantor. (See attached)

- Property ownership and assets are verified for all patients with cumulative balances greater than $2499.99.

- Once all collection efforts have been exhausted, a final notice letter is mailed to the guarantor. (See attached)

- Provided that all collection efforts have been exhausted, and a final notice has been sent to the guarantor, the account is reviewed with the Managers of Patient Access and Patient Financial Services for approval for referral to CCI, Attorney Simko or Attorney Tobin.

- If insurance information is identified, the insurance coverage is verified via the appropriate web site or with the carrier directly. If insurance is valid, the final bill and the letter are discarded and the verified insurance information is entered into the patient management system. Support Services is contacted for a new account generation.

Self-Pay Balance after Insurance or Insurance Rejection (F/C U & M) Inpatient and Outpatient Accounts

Timeline FC U:

Thirty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends statement to guarantor.

Sixty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends final notice letter to guarantor.

Ninety days from last financial class change, patient balance > $24.99, response code not J or K system changes financial class to Z (Bad Debt) (Z will change to G in 3 weeks)

Insurance 1 paid today, total insurance balance < 0, System transfers credit balance to Patient Column

Timeline FC M:

Thirty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends statement to guarantor.

Sixty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends statement to guarantor.

Ninety days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends final notice letter to guarantor.

One hundred twenty days from last financial class change, response code not J or K, patient balance > $24.99, total insurance balance=0, system transfers to financial class X (Medicare bad debt). ***(Will follow Siemen's Bad Debt Rules)***

- **The patient responsibility is verified via the explanation of benefits, the payer remittance, or the appropriate website.**

- **If the claim is denied for "information requested from member" the guarantor is contacted for the requested information which is then submitted to the insurance carrier. If the patient must respond directly to the insurance carrier, the guarantor is advised to contact the insurance carrier.**

If the claim is denied for "info requested from the provider", the requested information is identified and the account is resubmitted.

- If the claim is denied "patient responsibility" the guarantor is contacted for payment in full, settlement in full or time payments. If the guarantor indicates they are unable to pay, or cannot meet Danbury Hospital's time payment policy, the collector will refer the guarantor to the Financial Counselor for assessment for other programs such as Medicaid, charity, or P.A. 03-266. If the account balances for the outstanding accounts are less than $500.00 each, they are reviewed for small balance charity.

- If the guarantor cannot be reached at home or if there is no home telephone available, the place of employment is contacted if applicable. If guarantor cannot be reached at employment or is unemployed, an attempt is made to contact all "Emergency Contacts" identified in Patient Management.

- If a message is left for the guarantor, a follow-up call is made within 48 hours. A contact letter is mailed for all accounts where the collector has been unsuccessful in reaching the guarantor. (See attached)

- Property ownership and assets are verified for all patients with cumulative balances greater than $2499.99.

- Provided that all collection efforts have been exhausted, and a final notice has been sent to the guarantor, the account is reviewed with the Managers of Patient Access and Patient Financial Services for approval for referral to CCI, Attorney Simko or Atty Tobin.

Non-Contracted Insurance Timeline (F/C 4) Inpatient and Outpatient Accounts

Timeline FC 4:

Thirty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends statement to guarantor.

Sixty days from last financial class change, patient balance > $24.99, total insurance balance=0, system sends final notice letter to guarantor.

Ninety days from last financial class change, patient balance > $24.99, response code not J or K system changes financial class to Z (Bad Debt) (Z will change to G in 3 weeks)

Insurance 1 paid today, total insurance balance < 0, System transfers credit balance to Patient Column

Insurance 1 paid today, total insurance balance < 0, System transfers credit balance to patient column
(If patient balance is > $24.99, then system changes FC to U and sends statement to patient)

- **The insurance carrier is contacted to verify if the account was received and to identify why the claim was not processed.**
- **If the carrier indicates the claim is not on file, the subscriber's name, the insurance ID #, the group name and number if necessary, and the carrier address are verified. The Patient Management/Patient Accounting system is updated with the corrected information and, if necessary, the account is referred to the billing department for resubmission.**
- **If the carrier has denied the claim patient responsibility, the carrier is asked to either fax or send the denial.**
- **The denial is posted in patient accounting and forwarded to document imaging.**
- **The process for pure self-pay collections is followed as stated above.**

Revised 09/28/09

KEVIN'S COMMUNITY CENTER
Free Medical Clinic

(203) 426-0496
153 S.Main St
Newtown, CT

Open every Wednesday from 1-5 PM

KCC Services

Kevin's Community Center Clinic provides coordinated, comprehensive, personalized primary health care on a first-contact basis, incorporating medical diagnosis and treatment and personal support. The Clinic also supplies information about illness, including the prevention of disability and disease through early detection, education and treatment. These responsibilities, in conjunction with the evaluation and appropriate referral of patients who require specialist evaluation and treatment, comprise the scope of practice for Kevin's Community Center Clinic.

We see both scheduled and walk-in patients each Wednesday afternoon from 1 P.M. - 5 P.M. Appointments may decrease wait time.

Services Available

- Free primary health care
- Free Diabetes Clinic & Education
- Free Laboratory & Radiological Services
  - Services are offered through the generous support of Danbury Hospital and Housatonic Valley Radiological Associates.
- Free Referral Specialty Care
  - Our network of referrals include over 100 specialists from the greater Danbury area and the Danbury Office of Physican Services who donate their time.
- Prescription Medications
  - Most prescription medications are offered free of charge through our stock samples. The balance is offered at cost through the Drug Center Pharmacy of Newtown and through our patient assistance programs. To keep costs down we also take advantage of the generic Rx programs offered by many pharmacies.

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KEVIN'S COMMUNITY CENTER
Free Medical Clinic

(203) 426-0496
153 S.Main St
Newtown, CT

Open every Wednesday from 1-5 PM

KCC Patient Requirements

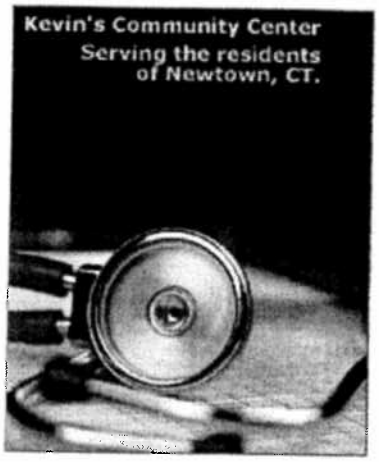
Our mission is to provide free primary health care for persons over the age of 18 who are uninsured or underinsured and who have limited financial resources. Patients, therefore, must meet the following eligibility criteria in order to be seen at the clinic.

- You must be uninsured or underinsured.
- Your income must fall within the centers guidelines. Individuals are "Eligible" for free medical services at KCC if they have household incomes between 100% and 200% of the Federal Poverty Level (FPL). Individuals are "restricted" or possibly eligible on a case by case review if their household income is between 200% and 300% FPL. Please call the clinic for more information if you are not sure you qualify.
- You must provide proof of residence in one of the following towns:
  - Newtown
  - Sandy Hook
  - Botsford
  - Hawleyville
  - Dodgingtown
  - Roxbury
  - Bridgewater

Kevin's Community Center has limited resources and cannot provide care to all those in need. The clinic will, therefore, give priority to those patients who demonstrate their willingness and determination to forge a real partnership, working together to improve their health status.

- We will not treat abusive or abrasive patients.
- We will not treat patients under the influence of drugs or alcohol.
- We expect patients to come to the clinic clean and appropriately dressed.
- We expect patients to be compliant with their medical treatment as prescribed.
- We expect patients to be honest about their medical, financial and insurance status.

If any of the above expectations are violated, Kevin's Community Center reserves the right to terminate services immediately, either temporarily or permanently. In such cases, a copy of the patient's records will be made available, at the patient's request, to the health care provider of his/her choice.



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48 Contiguous States and the District of Columbia

Family Size	% Gross Yearly Income									
	25%	50%	75%	81%	100%	133%	175%	200%	250%	300%
1	$2,708	$5,415	$8,123	$8,772	$10,830	$14,404	$18,953	$21,660	$27,075	$32,490
2	$3,643	$7,285	$10,928	$11,802	$14,570	$19,378	$25,498	$29,140	$36,425	$43,710
3	$4,578	$9,155	$13,733	$14,831	$18,310	$24,352	$32,043	$36,620	$45,775	$54,930
4	$5,513	$11,025	$16,538	$17,861	$22,050	$29,327	$38,588	$44,100	$55,125	$66,150
5	$6,448	$12,895	$19,343	$20,890	$25,790	$34,301	$45,133	$51,580	$64,475	$77,370
6	$7,383	$14,765	$22,148	$23,919	$29,530	$39,275	$51,678	$59,060	$73,825	$88,590
7	$8,318	$16,635	$24,953	$26,949	$33,270	$44,249	$58,223	$66,540	$83,175	$99,810
8	$9,253	$18,505	$27,758	$29,978	$37,010	$49,223	$64,768	$74,020	$92,525	$111,030

Family Size	% Gross Monthly Income									
	25%	50%	75%	81%	100%	133%	175%	200%	250%	300%
1	$226	$451	$677	$731	$903	$1,200	$1,579	$1,805	$2,256	$2,708
2	$304	$607	$911	$983	$1,214	$1,615	$2,125	$2,428	$3,035	$3,643
3	$381	$763	$1,144	$1,236	$1,526	$2,029	$2,670	$3,052	$3,815	$4,578
4	$459	$919	$1,378	$1,488	$1,838	$2,444	$3,216	$3,675	$4,594	$5,513
5	$537	$1,075	$1,612	$1,741	$2,149	$2,858	$3,761	$4,298	$5,373	$6,448
6	$615	$1,230	$1,846	$1,993	$2,461	$3,273	$4,306	$4,922	$6,152	$7,383
7	$693	$1,386	$2,079	$2,246	$2,773	$3,687	$4,852	$5,545	$6,931	$8,318
8	$771	$1,542	$2,313	$2,498	$3,084	$4,102	$5,397	$6,168	$7,710	$9,253

Boehringer Ingelheim AmeriCares Free Clinic of Danbury

Address:
76 West Street
Danbury, CT 06810

Directions to the clinic >

Phone:
203.748.6188

General Clinic Sessions:
Monday: 9:00 am to 5:00 pm
Tuesday: 9:00 am to 1:00 pm
Wednesday: 11:30 am to 7:00 pm
Saturday: 8:30 am to 12:00 pm

En Español | Em Português

For most medical services, appointments are preferred. Please note space is limited and patients without appointments will be seen, if time permits, in the order they sign in. Please note that the clinic is closed on holidays and holiday weekends. If you do not speak English, Portuguese or Spanish, please bring a friend or relative with you who can translate on your behalf.

Services Provided Read More >

- Outpatient medical care
- Pre-employment physical exams by appointment only (for established patients)
- Laboratory and diagnostic testing

If we cannot help you, we will try to refer you to an appropriate resource. All services are provided at the discretion of the clinic director.

© 2013 AmeriCares | 88 Hamilton Avenue | Stamford, CT 06902 | 800.486.HELP | 800.486.4357

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Eligibility

AmeriCares Free Clinics are open to those who are uninsured and who are without the financial resources to afford medical care.

To be eligible you must:

- Have no public or private health insurance
- Meet income guidelines – less than 200% FPL (see below)
- Be a resident of the area (for a list of eligible towns click here)
- Provide photo identification
- Provide income verification upon request
- Be 18 years or older for the Danbury and Bridgeport clinics
- Be accompanied by a parent or legal guardian for the Norwalk clinic if you are under 18 years of age

Financial Eligibility Criteria for Patient Services

2012 Income Guidelines - The AmeriCares Free Clinics program will provide health care services, free of charge, to eligible individuals with a total household income under 200% of the Federal Poverty Level. For 2012, this level of income would be:

Household size	Weekly income	Monthly income	Annual income
1	$430	$1,862	$22,340
2	$582	$2,522	$30,260
3	$734	$3,182	$38,180
4	$887	$3,842	$46,100
5	$1,039	$4,502	$54,020
6	$1,191	$5,162	$61,940
For each addl. Person add	$152	$660	$7,920

You may be asked to provide proof of household income (i.e. tax returns, pay stubs, unemployment checks) in order to ensure eligibility or to help obtain medicines at no cost to you.

Eligible Towns

The AmeriCares Free Clinics serve residents of the following towns:

Danbury Clinic

- Danbury
- Bethel
- New Milford
- Brookfield
- New Fairfield
- Redding

Norwalk Clinic

- Norwalk
- Darien
- New Canaan
- Westport
- Wilton
- Weston

Bridgeport Clinic

- Bridgeport
- Stratford
- Fairfield
- Westport
- Monroe
- Trumbull
- Milford

- Ridgefield
- Shelton

Clinic Expectations

The AmeriCares Free Clinics have limited resources and cannot provide care to all those in need. The Clinic will, therefore, give priority to those patients who demonstrate their willingness and determination to forge a real partnership, working together to improve their health status.

- We will not treat abusive or abrasive patients
- We will not treat patients under the influence of drugs or alcohol
- We expect patients to come to the clinic clean and appropriately dressed
- We expect patients to be compliant with their medical treatment as prescribed
- We expect patients to be honest about their medical, financial and insurance status

If any of the above expectations are violated, AFC reserves the right to terminate services immediately, either temporarily or permanently. In such cases, a copy of the patient's records will be made available, at the patient's request, to the health care provider of his/her choice.

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OUTPATIENT DEPARTMENT/FINANCIAL COUNSELORS
MATERNITY PACKAGE PLAN PRENATAL PROGRAM

The "Package Plan" fee is $1500.00 for prenatal care.

The qualification process includes an assessment to determine if the patient and / or the newborn will be eligible for any government sponsored medical assistance programs (Medicaid). The "Package Plan" fee will not be available to patients who qualify for government medical prenatal assistance.

Patients, who qualify for the package, are responsible for the $1500.00 "Package Plan" fee. Payments are to be made monthly to the Financial Counselor in the Outpatient Department. Bring all medical bills to the Financial Counselor for determination if included in the Package Plan.

Most patients who qualify for the "Package Plan" prenatal program will also qualify for Medicaid for delivery-related bills. If you qualify for Medicaid for your delivery, Danbury Hospital personnel will assist you with the Medicaid Application. If you do not follow through with a Medicaid application, you will be billed for all delivery charges.

COMPLETE PAYMENT IS REQUIRED BY THE SCHEDULED DELIVERY DATE.

If payment is not completed by the scheduled delivery date, the patient has defaulted on the "Package Plan Agreement." At that point, the patient will be responsible for total posted charges.

Covered Services

1. Prenatal outpatient services rendered in Danbury Hospital Outpatient Dept.
2. OB ultrasounds included up to, (2) scans. Further testing will be patient's responsibility.
3. Six weeks of postpartum care (outpatient services only).

No covered Services

1. Inpatient hospitalizations even if pregnancy related. These bills will be handled as routine inpatient accounts.
2. Expenses for non-Danbury Hospital physician services for mother and baby.
3. Services not related to prenatal, delivery and postpartum.
4. Inpatient hospitalizations during the six weeks of postpartum care.

I certify that I have read the above conditions and accept and agree to the terms specified.

_____
Signature Date

_____
Witness

COLLECTION COMPANIES

American Adjustment Bureau (AAB) handle debtor's names beginning: A-I
Address: 73 Field Street
Waterbury, Ct 06723

- Toll-free outside debtor line: 866-843-9729
- Toll-free inside client line: 866-267-1383

Credit Center, Inc. (CCI) handle debtor's names beginning: J-Z
Address: 7 Finance Drive
Danbury, Ct 06810

- Outside debtor line: 203-797-0505
- Direct line to our contact Neal Silverman: 203-749-2612

New as of 2010: TransContinental Credit & Collection Corp. (TCCC)
Contact: Elizabeth Robles, 914-993-9420, rep21@transcontinentalcredit.com
44 South Broadway STE 401 White Plains, NY 10601 Effective New Fiscal Year no longer sending accounts to agency

Efforts Used to Collect Payment: The hospital policy is to bill all insurances carriers for payment. Once it has been determined that all insurance payment has been made, any patient balances due are billed to the guarantor. A patient bill may also be generated if an insurance remittance received assigns a patient responsibility on a portion of a claim. Further, a Point of Service (POS) program is now in place to obtain up-front co-payments for some service types, like ER and ODS.

Whenever there is a patient balance due on a finalized account, our system generates bills to the guarantor address five times, at 30-day cycles. Each statement that goes out has a message advising the debtor to contact us to make payment etc. Each statement (#1-5) message increases in intensity regarding the need to pay the account balance and warning the debtor that the account will be turned over to an outside collection agency. Once an account reaches statement #6, no further bills can be generated, and the account can become eligible to be turned over to collections.

At that point, long as there is no insurance balance due, the account will come up on a turnover report that is run monthly by Billing Supervisor. She will decide if additional follow up is needed. Once the account has been turned over, both the date of the turnover and the collection company to which it was sent show on the patient account under Process an Account in BAR.

Note that an account may be turned over sooner if we find that we do not have a valid mailing address for the patient/guarantor. At least one attempt to send a bill

is made, and NMH pays extra postage to have mail returned to us with any applicable forwarding information. All returned patient mail is reviewed individually by one of our Customer Service Representatives. Every attempt is made to find a correct/new patient or guarantor address, including trying to contact them via telephone. If we are unable to obtain correct/new patient/guarantor mailing information, the account's statement status Is moved up to #6, making it eligible to be sent to collections on the next turnover report.

Each collection company has their own procedures for pursuing the debtors. They do not immediately report the bad debt on to a Credit Bureau. There is generally a 60-90 day grace period to allow the debtor to respond to the collection company's initial attempts to contact the debtor. As long as the debtor makes a payment arrangement with the collection company, and does not default on the agreement, the collection company will generally not report the debt. However, NMH has no involvement in the agreement or debt status once it has been turned over to a collection company, so our CSR can not guarantee the collection company's actions. Any patient contacting NMH is referred to the corresponding collection company to discuss payments and/or debt status.

- We receive requests for itemized bills from the collection companies. Unless they specify a UB92 form, we send them a 13/8. They need a statement that shows any payments made, who made them, and when the payments were received.
  - We may fax them the 13/8 if requested via phone message or fax.
  - Hardcopy requests are to be returned by mail with the 13/8 attached.
- The collection companies also go legal with certain debts. Depending on the total amount of the debt, the collection company will send us a request for our authorization for that action. We have to check that the account debt matches the amount noted on the collection company request, then attach a itemized statement (13/8), and forward the package to the Director of Patient Accounts for review and authorization. Each collection company uses a different attorney group to handle their legal claims. Usually the collection company will bundle several accounts for a guarantor together under the same suit. This means that a single suit may consist of more than one claim for a single patient's claims, or multiple family members' claims.
- As much as possible, any patient/guarantor calls regarding bad debt accounts should be referred to the corresponding collection company. They can access our Meditech system and check current balances and the notes screen. However, they often need to call to confirm information, payments, or the reason for the patient's visit, when the patient does not recall it. Also, patients/guarantors made need us to go over their accounts for

status since the collection companies combine some accounts when they go legal on them.

- Frequently a debtor will present in person with a collection company letter, or the collection company's attorney's letter, or even legal court documents regarding a debt with NMH. As noted above, the collection company may combine several accounts onto a legal suit, so we have to contact them in order to determine which accounts are part of any given suit.
- Any payment that a debtor makes is logged at both NMH and the collection company. When the payment is made through the collection company, or through the mail to NMH, the information is exchanged via a written monthly report. If a patient calls the payment in via a credit card, or pays in person at the window, then the CSR must contact the collection company to advise that the payment has been made.
- Note that we can accept only payments for patient balances due on our accounts. If the debtor owes legal fees on a reported bad debt account, they must make payment of same to the collection company, the associated attorney, or the court as is applicable.
- We can also utilize the collection companies when we need new guarantor address and/or phone number information. If the guarantor has other accounts in bad debt, the collection company may have up to date information and also has access to people search programs that we do not have.
- NMH does not have the ability to check a patient's credit report, nor can we change the status of a debt that has been reported to any of the Credit Bureaus. Only the collection companies can access and handle the reporting to the Bureaus. When the debtor pays off a debt that has gone legal, the collection company will release the appropriate paperwork to the debtor. In the event that a lien has been applied, the debtor must take the release of lien information to the Town Hall to complete the release of lien with the town in which the lien property is located.

COLLECTION COMPANIES.doc
Updated 2/2010, lms
Updated 2/17/11 DEM