

Mt Sinai Campus

APPLICATION FOR FINANCIAL RELIEF

Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Social Security #: _____ Home Phone#: _____

Employer's Name & Address: _____

Number - Household Members: _____ Other Family Income: \$ _____

Patient's gross income: \$ _____ Total Family Income: \$ _____

Service Date(s): _____ Acct #: _____ Balance: \$ _____

Proof of income provided: _____ Pay stubs _____ Fed'l Tax Return _____ Other: *SSI, State denial*
(4 current) (most recent)

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (*Medicaid, Medicare, Insurance, etc.*) which may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance.

I understand that this application is made so that the hospital can judge my eligibility for Financial Relief, based on the established criteria of the hospital. If any information I have given proves to be untrue, I understand the hospital may re-evaluate my financial status and take whatever action that is appropriate.

I also understand that all information requested must be received within ten (10) working days from date of request.

Date of request Person Completing Application Applicant's signature

ELIGIBILITY DETERMINATION (For Office Use Only)

Date application received: _____ Documentation received: _____

The applicant is **eligible** for % _____ = \$ _____ Financial Relief Funds. New balance: \$ _____.
_____ The applicant's request for Financial Relief Funds has been **denied** for the following reason(s):

_____ Over-income _____ Did not pursue available resources or failed to comply _____ No income

_____ Other reason: _____

Date determination (deny/eligible): _____ Authorized Signature: _____

Mt Sinai Campus

Financial Relief

Patient **must** supply the following documentation in order to determine eligibility:

An application for State Medical Assistance (Medicaid) must be completed for those patients with verified income below 100% poverty guideline. If your request for State assistance is denied, obtain a copy and attach it to your completed Financial Relief Application.

Attach proof of income for the last twelve (12) months for you and your spouse. (Federal Tax Return, most current date)

Attach copy of last two (2) by weekly or last four (4) current pay stubs from date of request for Financial Relief Assistance for you and your spouse (*significant other*).

Attach copy of unemployment, pension, voucher, social security or disability benefits. (*if applicable*)

Provide social security numbers for all dependents listed in the number of family size, if they are not listed on your last Federal Tax Return. Birth certificates may also be requested.

For ***undocumented citizens***, the procedure to grant Financial Relief Funds are as follows:

Copy of alien status; passport/visa. If you are a permanent resident, but in the US for less than five (5) years, you are ***not*** eligible for State Assistance.

However, your sponsor IS responsible for any financial or medical services that are provided to you. If you have no means to pay this hospital debt and you're applying for assistance, you **must** furnish us with your **sponsor's income** to determine your eligibility. Using the same criteria as listed above without the need for State denial. This information must also be received within ten (10) business days from received date or application will be denied.

Any questions or concerns, please feel free to call our office, Monday through Friday; 8:00am – 4:00pm at 860-714-4952. Thank you

Mt Sinai Campus

APLICACIÓN PARA ASISTENCIA FINANCIERA

Nombre: _____

Dirección: _____

de Seguro Social: _____ # de telefono: _____

Nombre y dirección del empleador: _____

Numero de dependientes: _____ Ingreso de otros familiares: _____

Ingreso del paciente: _____ Ingreso total de la familia: _____

Fecha(s) de servicio: _____ # de cuenta: _____ Balance: _____

Prueba de ingreso: Talonarios _____ (4 recientes)	Forma de Impuestos: _____ (recientes)	Otros: _____ (SSI, State denial)
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Certifico que la información suministrada es cierta segun mi leal saber. Ademas, haré cualquier aplicación para asistencia (medicaid, medicare, seguros, etc.) las cuales servirán para cubrir las deudas del hospital. Tomaré cualquier acción que sea razonablemente necesaria para obtener dicha asistencia.

Yo entiendo que esta aplicación esta hecha para que el hospital pueda juzgar mi elegibilidad para asistencia financiera, basados en el criterio establecido en los archivos del hospital. Si cualquier información que yo haya proveido prueba ser falsa, yo entiendo que el hospital re-evaluara mi estado financiero y tomará la acción que sea apropiada.

Entiendo que la prueba de ingreso debe ser sometida dentro de 10 dias laborables ha partir de la fecha del pedido.

_____ fecha del pedido _____ Persona completando la Aplicación _____ Firma del aplicante

DETERMINACIÓN DE ELEGIBILIDAD (uso de la oficina)

Fecha de haber recibido la aplicación: _____ Verificación de Ingreso: _____

El/La aplicante es elegible para % _____ = \$ _____ ayuda financiera. Balance actual: \$ _____

El/La aplicante es elegible para _____ % ayuda financiera

_____ El pedido del aplicante para servicios gratis o reducidos ha sido negado por la(s) razon(es) siguientes:

_____ Sobre Ingreso _____ No aplicó para los recursos disponibles _____ Ningun Ingreso

_____ Otros

Fecha Determinante de elegibilidad: _____ Firma Autorizada: _____

Mt Sinai Campus

Ayuda Financiera

Los pacientes deberán presentar los siguientes documentos para poder determinar su elegibilidad:

Una solicitud del Departamento de Servicios Sociales debe ser completada para los pacientes con un ingreso menor de 100% de los estándares de pobreza. Si su solicitud para servicios sociales es denegada, favor de obtener una copia y adjúntela a su solicitud de Ayuda Financiera que ofrece el hospital.

Envíe prueba de ingreso de los últimos 12 meses de usted y su conyugue. Esto es la Planilla Federal de Impuestos del 2010 (Federal Tax Return).

Envíe una copia de los últimos 4 talonarios (suyos y de su conyugue), desde el día en que la aplicación para Asistencia Financiera del Hospital fue completada.

Si está desempleado y recibe beneficios, envíe una copia del comprobante de beneficios de desempleo, del seguro social o de incapacidad.

Provea el número de seguro social de todos los dependientes listados en el encasillado que especifica la cantidad de personas en la familia, y que **no** aparecen en la Planilla Federal de Impuestos Contributivos (Federal Tax Return).

Para ciudadanos indocumentados, el procedimiento para aprobación la Asistencia Financiera es como sigue:

- Usaremos el mismo criterio enlistado.
- Necesitamos una copia de su estado legal; por ejemplo, el pasaporte/visa.
- Si es Residente Permanente (tarjeta verde), y ha estado en los Estados Unidos por menos de 5 años, usted no cualifica para asistencia del Estado.

Pero, su patrocinador es responsable por todos los servicios médicos o financieros. Si usted no tiene los recursos para pagar su factura y está aplicando para ayuda financiera del hospital, usted debe proveer la prueba de ingreso de su patrocinador para determinar si cualifica para asistencia.

Si esta información no es recibida en 10 días, la solicitud será negada.

Cualquier pregunta, favor de llamar a nuestras oficinas de lunes a viernes de 8:00am a 4:00pm al 860-714-4952. Muchas Gracias.

Medicaid they will be offered hospital financial relief based on the Medicare allowed amounts.

- If a patient is approved for Medicaid with no spenddown, the proof of eligibility determination from the Department of Social Services can be used as verification of their income and be eligible for 100% financial assistance .
- If the balance on an account is the result of a spenddown the income guidelines will apply to determine eligibility. The Medicare allowed calculation will apply so the balance may not be eligible for financial assistance.

Effective 1/1/2014: Husky D patients will no longer be deemed eligible for a spend down. An application for assistance needs to be completed through Access Health CT during open enrollment.

4. Eligibility is determined on family size and current income.

- a. Income eligibility is based on the federal poverty guidelines. Patients with income levels **under 200%** of the federal poverty guidelines who are ineligible for State Medical Assistance will receive 100% financial relief.
- b. Patients with income levels between **200% to 250%** of the federal poverty guidelines who are ineligible for State Medical Assistance will be eligible for financial assistance based upon Medicare allowed amount. This may or may not provide a discount on the patient balance that is owed.

Self Pay Patients with income over 250% of the federal poverty guidelines will not be eligible for financial assistance but may still receive a self pay discount if applicable.

Examples:

- **If an insurance payment (cash from insurance) is the same or greater than the Medicare allowed amount for the same service, there will be no patient responsibility. The patient balance will be adjusted 100% with the financial assistance code 97000039.**
- **If the insurance payment is less than the Medicare allowed amount the patient is responsible to pay up to the Medicare allowed. Any amount over the Medicare allowed will be adjusted with the financial assistance code 97000039.**
- **Patients with health insurance who have medically necessary inpatient and outpatient services will be eligible to apply for financial assistance in the following instances:**
 - **Reached their maximum benefits**
 - **Entire procedure is non covered due to limitations of their policy or diagnosis**

Patients within the 200-250% of the federal poverty guidelines will be required to

pay the Medicare allowed amount.

Patients over 250% of the federal poverty guidelines will be granted the self pay discount.

5. The Self Pay Manager and appropriate personnel determine eligibility within 30 days of receipt of a completed application.
6. Assessment for other free bed funding is completed as part of the financial assessment

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

<\$4,999 - Customer Service Rep/Financial Counselor Team Leader
\$5,000-\$24,999 - Supervisor
\$25,000-\$49,999 - Manager
\$50,000-\$99,999 - Director of Patient Financial Services
>\$100,000 - VP, Revenue Cycle
After obtaining approval, staff will apply adjustment.

To be Noted

- For all financial relief cases where the patient or spouse is self employed, the gross income will be used after the business expenses are deducted. This information is obtained from the "Profit and Loss Statement" or income reported on the 1040 or 1040A.
- Patients seeking financial relief who are under sponsorship of relatives are determined eligible if the sponsor provides the appropriate income/household documentation. Eligibility is determined on income.
- Cosmetic and Bariatric Procedures are excluded from Financial assistance
- Liability Cases that have secured liens are excluded from Financial Assistance
- Undocumented patients who are eligible for Medicaid Emergency Medical coverage (for their inpatient emergency account) are automatically eligible for financial assistance when proof of eligibility is determined from the Department of Social Services.

CROSS REFERENCES:

Self Pay Billing and AR Management Policy
Emergency Medical Screening and Stabilization/ EMTALA

APPROVED BY: Policy requires Director and Vice President approval.

Director(s): Sarah Alber

Date:

Vice President(s): Nicole Schulz

Date:

/s/ Sarah Alber

1/15/14

1/15/14

REPLACES:

REVISED DATE: 10/1/03; 3/15/04;9/01/04; 11/01/04; 03/07/05; 10/01/05; 10/1/06; 3/1/07;
4/11/08; 5/22/09, 7/1/2011, 1/23/2012 , 7/1/2012, 7/8/2013, 1/15/2014

 <p>Policy</p>	Title: SELF PAY BILLING AND AR COLLECTION POLICY		
<input checked="" type="checkbox"/> Saint Francis Hospital and Medical Center <input checked="" type="checkbox"/> Mount Sinai Rehabilitation Hospital <input type="checkbox"/> Saint Francis Medical Group, Inc. <input type="checkbox"/> Saint Francis Care Medical Group, P.C. <input type="checkbox"/> Asylum Hill Family Medicine Center, Inc. <input type="checkbox"/> Saint Francis Behavioral Health Group, P.C.	Proponent Department Business Office	Number	Level <input type="checkbox"/> System <input type="checkbox"/> Division <input checked="" type="checkbox"/> Department
	Category <input checked="" type="checkbox"/> Administrative <input type="checkbox"/> Clinical <input type="checkbox"/> HR <input type="checkbox"/> EOC	Published Date 7/29/2011	Review Cycle <input type="checkbox"/> 1 year <input checked="" type="checkbox"/> 3 years

PURPOSE: It is the policy of Saint Francis Hospital & Medical Center that all patients who have received services and that have outstanding financial obligations are given fair and objective opportunities to satisfy these responsibilities. To that end, Saint Francis Hospital commits to the following: Patients/patient guarantors shall receive a summarized bill including but not limited to encounter specific information including dates of service, summarized charges, discounts, payments, adjustments and amounts owed.

- Patients/patient guarantors will be properly informed of the various options available to satisfy their outstanding financial obligation(s) including assistance through the Access Health CT, State of Connecticut's Medicaid Assistance Program as well as through St. Francis Hospital's internal financial assistance program, and recurring payment plan guidelines.
- Patients/patient guarantors will be given an appropriate amount of time (4 statements or 120 days) to respond to such notices of outstanding financial obligations.
- Patients/patient guarantors will be treated with respect and compassion in accordance with the Saint Francis Hospital & Medical Center mission.
- Return mail without other non-identified information is returned, the account may to collections before 120 days.

SCOPE:

This policy applies to the Business office and hospital staff

POLICY:

Self-Pay Billing: Execution of the self-pay billing cycle.

Primary self-pay balances, those balances for which there is no insurance coverage, or self pay balances after insurance has been processed, will receive a series of four statements when the account is released from billing.. Self-pay balances resulting from an insurance payment will receive a series of four statements beginning five days from the financial class change to self-pay.

- First, an account is generated and held for the appropriate min days which allows the charges to be associated with the patient encounter. After the min days are satisfied the account is moved from pre-receivable status to active accounts receivable status in the hospital's receivable system.
- Second, a statement displaying a summary of the total charges and the outstanding balance (after any discounts and recent payments have been applied) is generated and mailed to the patient through a contracted agent.
- Simultaneously a file containing the billed inventory is electronically transferred to a contracted self-pay customer service agent to initiate contact and work with patients for account resolution.

Each statement includes a specific message based upon the status and age of the account. The statement cycle can be reset to previously issued datamailer statements through one of two means: Business Office staff can manually reset the dunning cycle or a change in the encounter's financial class. The statement intervals are generated in 30 day intervals and the entire

dunning cycle, assuming no interventions, lasts 120 days. All accounts which have an established recurring payment arrangement (payment plan) will receive an alternative self-pay dunning cycle. Payments on payment arrangements must have consistent payment in accordance with the plan. If installment payments are missed the account is eligible for collection.

Self-pay A/R Management: Execution of Self-pay Collection Efforts

Collection efforts on self pay accounts are assigned to a contracted customer service agent from the day the account is ready for billing. The contracted agent receives daily billing files as self-pay claims are generated.

- Follow-up and collection activities will commence upon receipt of the referral.
- Accounts are run through a predictive dialer application/voice broadcasting system to establish initial contact with the patient/patient guarantor. Patients whose established phone number has a voice answering system are left pre-recorded messages indicating the nature of the call and requesting them to contact the St. Francis Billing & Customer Service Department at the appropriate toll-free number.
- All patients shall be made aware of the various financial assistance options available to them including but not limited to assistance through Access Health CT, the State of Connecticut's Medicaid Assistance program, as well as St. Francis' internal financial relief program and recurring payment plan guidelines.
- All efforts should be made to establish payment plans that resolve an outstanding balance within a reasonable time period. All accounts which have established a recurring payment arrangement in good standing consistent monthly payments for the agreed upon amount are exempt from any bad debt write-off protocols. Should an account become delinquent, a late notice is generated at 15 days a delinquency notice at 30 days past due. If a payment is not received within two months (60 days), a final notice is generated and the account will become eligible for bad debt by changing the financial class and written of at the end of the month.

Self-pay Write-offs: Execution of Bad Debt Write-off Protocols

- If a mutually agreed upon recurring arrangement is not establish or if the account is not resolved within the 120 day billing cycle, the account automatically becomes eligible for bad debt write-off. Automatic assignment is changed to reflect bad debt assignment of one of two contracted collection agent.
- A system generated write off report is run and sent to management and each collection agent to review.

Approval of bad debt accounts are as follows:

- \$5,000-\$24,999 - Supervisor
- \$25,000-\$49,999 - Manager
- \$50,000-\$99,999 - Director of Patient Financial Services
- >\$100,000 - VP, Revenue Cycle

Upon completion of the report review the account is automatically written off to Bad Debt at the end of the month.

- The account balance is subsequently removed from the active accounts receivable and becomes part of the bad debt receivable. Any patient payments secured on this receivable are classified as recoveries to bad debt. Contracted agents will pursue recoveries of referred accounts for a period of 180 days and perform similar referral management and collection activities as described above.
- Any unpaid balance in bad debt with no activity for 180 days, will be returned to the hospital and get referred for secondary placement see **AAB & LEVIN BAD DEBT RETURNS TO EOS CCA PROCEDURE**

REFERENCES:

CROSS REFERENCES: Financial Relief Policy, Emergency Medical Screening and Stabilization/ EMTALA Policy, and AAB & LEVIN Bad Debt returns to EOS CCA procedure.

APPROVED BY: Policy requires Director and Vice President approval.

Director(s): Sarah Alber

Date:
2/6/2014

Vice President(s): Nicole Schulz

Date:
2/6/2014

REPLACES: 3/1/03

Revised Date: 10/1/03; 3/15/04; 9/1/04; 11/01/04; 03/07/05; 10/1/05; 10/01/06; 3/01/07; 4/11/08; 2/21/11; 07/29/2011;
5/22/2013, 2/6/2014

**Saint Francis Hospital and Medical Center
Community Assistance Program
Eligibility Criteria On or After 02/01/2014**

2014 Poverty Guidelines

FAMILY SIZE	ANNUAL GROSS INCOME		
	POVERTY	200%	250%
1	11,670	23,340	29,175
2	15,730	31,460	39,325
3	19,790	39,580	49,475
4	23,850	47,700	59,625
5	27,910	55,820	69,775
6	31,970	63,940	79,925
7	36,030	72,060	90,075
8	40,090	80,180	100,225
9	44,150	88,300	110,375
10	48,210	96,420	120,525

SLIDING SCALE

Rate

- A = SELF PAY DISCOUNT only
- B = PATIENT OWES MEDICARE
- C = FULL ASSIST 100%

SLIDING SCALE

WEEKLY GROSS INCOME	MONTHLY GROSS INCOME	ANNUAL INCOME	FAMILY SIZE											
			1	2	3	4	5	6	7	8	9	10		
0 - 448	0 - 1,945	23,340	C	C	C	C	C	C	C	C	C	C	C	C
449 - 560	1,946 - 2,431	29,175	B	C	C	C	C	C	C	C	C	C	C	C
561 - 603	2,432 - 2,622	31,460	A	C	C	C	C	C	C	C	C	C	C	C
604 - 759	2,623 - 3,298	39,580	A	B	C	C	C	C	C	C	C	C	C	C
760 - 915	3,299 - 3,975	47,700	A	A	B	C	C	C	C	C	C	C	C	C
916 - 949	3,976 - 4,123	49,475	A	A	B	B	C	C	C	C	C	C	C	C
950 - 1,071	4,124 - 4,652	55,820	A	A	A	B	C	C	C	C	C	C	C	C
1,072 - 1,144	4,653 - 4,969	59,625	A	A	A	B	B	C	C	C	C	C	C	C
1,145 - 1,226	4,970 - 5,328	63,940	A	A	A	A	B	C	C	C	C	C	C	C
1,227 - 1,338	5,329 - 5,815	69,775	A	A	A	A	B	B	C	C	C	C	C	C
1,339 - 1,382	5,816 - 6,005	72,060	A	A	A	A	A	B	C	C	C	C	C	C
1,383 - 1,538	6,006 - 6,682	80,180	A	A	A	A	A	A	B	C	C	C	C	C
1,539 - 1,694	6,683 - 7,358	88,300	A	A	A	A	A	A	B	B	C	C	C	C
1,695 - 1,728	7,359 - 7,506	90,075	A	A	A	A	A	A	B	B	B	C	C	C
1,729 - 1,849	7,507 - 8,035	96,420	A	A	A	A	A	A	A	B	B	C	C	C
1,850 - 1,922	8,036 - 8,352	100,225	A	A	A	A	A	A	A	B	B	B	C	C
1,923 - 2,117	8,353 - 9,198	110,375	A	A	A	A	A	A	A	A	B	B	B	C
2,118 - 2,312	9,199 - 10,044	120,525	A	A	A	A	A	A	A	A	A	A	B	C

**Saint Francis Hospital and Medical Center
Community Assistance Program
Eligibility Criteria On or After 05/01/2013**

2013 Poverty Guidelines

FAMILY SIZE	ANNUAL GROSS INCOME		
	POVERTY	200%	250%
1	11,490	22,980	28,725
2	15,510	31,020	38,775
3	19,530	39,060	48,825
4	23,550	47,100	58,875
5	27,570	55,140	68,925
6	31,590	63,180	78,975
7	35,610	71,220	89,025
8	39,630	79,260	99,075
9	43,650	87,300	109,125
10	47,670	95,340	119,175

SLIDING SCALE

Rate

- A = SELF PAY DISCOUNT only
- B = PATIENT OWES MEDICARE
- C = FULL ASSIST 100%

WEEKLY GROSS INCOME		MONTHLY GROSS INCOME		ANNUAL INCOME	SLIDING SCALE FAMILY SIZE									
					1	2	3	4	5	6	7	8	9	10
0 - 441	441	0 - 1,915	1,915	22,980	C	C	C	C	C	C	C	C	C	C
442 - 551	551	1,916 - 2,394	2,394	28,725	B	C	C	C	C	C	C	C	C	C
552 - 595	595	2,395 - 2,585	2,585	31,020	A	C	C	C	C	C	C	C	C	C
596 - 749	749	2,586 - 3,255	3,255	39,060	A	B	C	C	C	C	C	C	C	C
750 - 903	903	3,256 - 3,925	3,925	47,100	A	A	B	C	C	C	C	C	C	C
904 - 936	936	3,926 - 4,069	4,069	48,825	A	A	B	B	C	C	C	C	C	C
937 - 1,058	1,058	4,070 - 4,595	4,595	55,140	A	A	A	B	C	C	C	C	C	C
1,059 - 1,129	1,129	4,596 - 4,906	4,906	58,875	A	A	A	B	B	C	C	C	C	C
1,130 - 1,212	1,212	4,907 - 5,265	5,265	63,180	A	A	A	A	B	C	C	C	C	C
1,213 - 1,322	1,322	5,266 - 5,744	5,744	68,925	A	A	A	A	B	B	C	C	C	C
1,323 - 1,366	1,366	5,745 - 5,935	5,935	71,220	A	A	A	A	A	B	C	C	C	C
1,367 - 1,520	1,520	5,936 - 6,605	6,605	79,260	A	A	A	A	A	A	B	C	C	C
1,521 - 1,674	1,674	6,606 - 7,275	7,275	87,300	A	A	A	A	A	A	B	B	C	C
1,675 - 1,707	1,707	7,276 - 7,419	7,419	89,025	A	A	A	A	A	A	B	B	B	C
1,708 - 1,829	1,829	7,420 - 7,945	7,945	95,340	A	A	A	A	A	A	A	B	B	C
1,830 - 1,900	1,900	7,946 - 8,256	8,256	99,075	A	A	A	A	A	A	A	B	B	B
1,901 - 2,093	2,093	8,257 - 9,094	9,094	109,125	A	A	A	A	A	A	A	A	B	B
2,094 - 2,286	2,286	9,095 - 9,931	9,931	119,175	A	A	A	A	A	A	A	A	A	B

 SAINT FRANCIS <i>Care</i> Procedure	Title: BAD DEBT WRITE OFF PROCEDURE		
<input checked="" type="checkbox"/> Saint Francis Hospital and Medical Center <input checked="" type="checkbox"/> Mount Sinai Rehabilitation Hospital <input type="checkbox"/> Saint Francis Medical Group, Inc. <input type="checkbox"/> Saint Francis <i>Care</i> Medical Group, P.C. <input type="checkbox"/> Asylum Hill Family Medicine Center, Inc. <input type="checkbox"/> Saint Francis Behavioral Health Group, P.C.	Proponent Department DEPARTMENT BUSINESS OFFICE	Number 	Level <input type="checkbox"/> System <input type="checkbox"/> Division <input checked="" type="checkbox"/> Department
	Category <input checked="" type="checkbox"/> Administrative <input type="checkbox"/> Clinical <input type="checkbox"/> HR <input type="checkbox"/> EOC	Published Date July 1, 2011	Review Cycle <input type="checkbox"/> 1 year <input checked="" type="checkbox"/> 3 years

PURPOSE:

The purpose of this procedure is to define how to write accounts off to bad debt.

SCOPE:

This procedure applies to the Business Office-Patient Accounting Department.

PROCEDURE:

A. BAD DEBT WRITE OFF PROTOCOL:

All Self Pay accounts shall be given a 45% discount off of billed charges effective 1/1/12. This discount was applied at the time of initial billing.

Account balances which have not been resolved after a series of 4 patient statements during the dunning cycle which is 120 day assuming no interruptions, automatically becomes eligible for bad debt write-off.

- Exclusions to this protocol are: Mail Returns, Small Balance Write off, Unresolved patient disputes or billing issues, and Bankruptcy discharges. Which may result in early placement to bad debt or early discharge of an account .

The financial class assignment is automatically changed to reflect the corresponding assignment of the bad debt to one of two contracted collection agents. Effective 11/1/2011: Claim inventory is split alphabetically with patient last names beginning with the letters A – MI being assigned to American Adjustment Bureau staff (financial class code 951 - American Adj Bur BD, financial class code 953 - BD Mcare SP - AAB) and the remainder of the alphabet MJ - Z being assigned to Nair & Levin staff (financial class code 920 - Nair & Levin BD, financial class code 972 - BD Mcare SP - N&L).

- A report of accounts eligible for bad debt greater than \$5,000 is generated and distributed to the Self Pay Manager, Director and Vice President.

The account balance is subsequently removed from the active accounts receivable and at month end, the system will automatically write off accounts in these financial classes which becomes part of the bad debt receivable. Any patient payments secured on this receivable are classified as recoveries to bad debt.

Contracted agents will pursue recoveries of referred accounts for a period of 180 days and perform similar referral management and collection activities as described above. Upon culmination of the 180 day holding period, any unpaid balances will be returned to the hospital.

Accounts that are returned as uncollectible may be considered for secondary placement with a contracted collection agency EOS CCA. The appropriate returned transaction code is applied to the account and the financial class is changed to 931 EOS CCA bad debt 932 EOS CCA Med Bad Debt. An electronic inventory is sent to the collection agency to pursue accounts for an additional 180 days. Any unpaid balances will be returned to the hospital.

B. Write Off/Account manually:

Accounts that need to be written off manually to an outside Collection Agencies can be flagged for write off by simply changing the Financial Class of the account to the agency.

- Other agencies should be written off in the following manner:
 - 1) Change the Financial Class to the Agency
 - 2) SFS Pathway is: PA, PM, AR, WO - In the write off service code enter 97111111
In the balance forward service code enter 97970000
Answer Yes to the write off question.
- Example:

Name: KOLE SUSAN VT: I Acct: 100000095 Acct. Bal: 1300.00
AR Per: Entire Account AS: A FC: SAGA/CITY(REVENU Per Bal: 1300.00

Write-Off Service Code: 97111111 BAD DEBT MOVE
Balance Forward Service Code: 97970000 SFS BAD DEBT WRITE O

Write-Off This Account? YES

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

C. REACTIVATING A BAD DEBT ACCOUNT:

- The write off reactive function in the PM menu should be used to bring the account back from bad debt. PA/PM/AR/WO. The codes to use are 97222222 AR Move in the reactivate the account and 97970000 as the Balance forward code.
- Example:

Name: ABERNATHY DENISE VT: C Acct: 50230028799 Acct Bal: 135.31
AR Per: Entire Account AS: B FC: ELIG MEDICAID AUT Per Bal: 135.31

Re- Activate Service Code: 97222222 AR MOVE
Balance Forward Service Code: 97970000 SFS BAD DEBT WRITE O

Re-Activate This Account? YES

C. WRITING ACCOUNTS OFF TO ZERO BALANCE:

- The write off to Bad Debt is only intended for accounts that are being followed up by agencies. Accounts being written off for other reasons (i.e. Denied timely filing, bankruptcy, etc.) should be done through transaction entry. PA, PM, FIN, TE.
- The following adjustment codes should be used:
 - ⇒ 97000011 - Bad Debt Wo
 - ⇒ 97000023 - Small Balance
 - ⇒ 97000026 - Bankruptcy
 - ⇒ 97100085 - Medicare
 - ⇒ 97000610 - Denied Timely Filing

(All other bad debt write off codes have been inactivated so you will not be able to use them.)

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

D. INTERRUPTION OF DEBT COLLECTION PROCESS

- All outside collection agencies will be providing a copy of the hospital free bed/financial assistance summary in all communication to a patient. (i.e. hospital one page summary sheet).
- At any time during the collection process, if the collection agency has determined that the patient may qualify for a free bed fund or financial assistance, the account will be referred back to the hospital. At this time all outside collection activity will stop until financial assessment is completed.

E. Second Placements

- The Hospital reserves the right to send accounts that have been closed by the primary collection agency to a secondary agency for further collection efforts. The above process will remain the same for secondary placements..

REFERENCES:

CROSS REFERENCES:

APPROVED BY: Policy requires Director approval.

Director(s): Sarah Alber

/s/ Sarah Alber

Date:

3/21/2012

REPLACES:

January 23, 2009 procedure
