

The Stamford Hospital

Subject: **Bad Debt Procedures**

Policy # 0004

Implemented: 05/31/07

Reference(s):

Revisions: 10/25/12, 11/08/13, 11/12/13, 10/06/14, 10/05/15

Approval: EM

Reviewed

Department: Patient Business Services

Page: 1 of 5

Purpose

Outline the process of referrals for Stamford Hospital's patient accounts to external EBO or BD Agencies or direct referrals to Collection Attorneys.

Policy

True Self Pay Accounts

Self-pay accounts are identified in the Meditech system by financial classes 11, 12 and 16.

Self Pay balances after insurance

All financial classes excluding 11, 12 and 16.

A-K is sent to Agency A (EBO) *(account remains in AR)*

L-Z is sent to Agency B (EBO) *(account remains in AR)*

Accounts for deceased patient's are sent to Agency A (DPR) or Agency B (DPR) to screen for Estate and Probate filings.

True Self Pay Accounts:

- The Financial Assistance Counselors review inpatient accounts, outpatient observation, pre-natal clinic accounts, specialty clinic accounts and selective outpatient accounts for the following.
 - a. Eligibility for any Federal or State Assistance Programs
 - b. Payment Agreements
 - c. Eligibility for the Stamford Hospital Financial Assistance Program.
 - d. Free Bed Funds

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

*EBO- Extended Business Office

Collection Cycle SP	FB	Stamford Hospital Statement 1	Agency EBO
	Day 31	T/O to agency	Statement 2
	Day 45		Call Series* On dialer
	Day 61 thru Day 99		
	Day 100 Wait time 20 days		Final notice
	Day 120		T/O to BD
*Calls not to exceed 8 Minimum of 4			

- If the accounts are not pending Federal, State or Financial Assistance, set up on a payment plan, or approved for a reduction through our financial assistance program, on day 31, the accounts are referred to our AR Extended Business Offices (EBO).
- A second statement is generated to the patient on day 31 from either agency. On day 45, the “Call Series” on a dialer begins through day 99. A minimum of 4 calls will be made but not to exceed 8. On day 100 a final notice is sent to the patient with a wait time of 20 days. Each EBO tracks the 120 days aging requirement using an automated monitoring system timeline from the date the first patient statement is generated.
- Unless the statement is revised to “hold”, or re-sequenced at the discretion of the EBO collectors, the account is referred back to the hospital for a review for bad debt referral, adjustments, bankruptcy, or free service at approximately 120 days from the first statement date.
- The final notice is sent to the patient at day 100 notifying them that if they fail to respond within 20 days, their account may be referred to a BD agency or attorney.
- The accounts are returned from the EBO with an assigned cancel back code. These are manually reviewed, assigned to an external agency or collection. At the discretion of the Manager of PBS, accounts may be listed directly to collection agencies or attorneys with the following the alpha split.

A-K is sent to Agency B (BD)
L-Z is sent to Agency A (BD)

- Pre-listed accounts are reviewed by the Team Leader for the appropriate referral and transfer of these accounts to BD status.

-

Self Pay after insurance Accounts:

- After insurance payments and there is patient liability statement 1 is sent to the patient. There is a 30 day hold.
- If after 30days, balance remains, statement 2 is generated and mailed to the patient.
- At day 61, if there is no response from the patient, account is listed with the EBO.

Collection Cycle		Stamford Hospital	Agency EBO
SP/after Ins	FB	Statement 1	
Day 30 Hold		Statement 2	
Day 61 thru Day 99		T/O to agency	Call series**
Day 100 Wait time 20 days			Final notice
Day 120			T/O to BD
** Calls not to exceed 5			
Minimum of 4			

A-K is sent to Agency A (EBO)

L-Z is sent to Agency B (EBO)

- Unless the statement is revised to “hold”, or re-sequenced at the discretion of the EBO collectors, the account is referred back to the hospital for a review for bad debt referral, adjustments, bankruptcy, or free service at approximately 120 days from the first statement date.
- The final notice is sent to the patient at day 100 notifying them that if they fail to respond within 20 days, their account may be referred to a BD agency or attorney.
- The accounts that are returned from the EBO with an assigned cancel back code. These are manually reviewed, assigned to an external agency or collection attorney and prelisted for bad debt turnover at the end of the week.
- At the discretion of the Manager of PBS, accounts may be listed directly to collection agencies or attorneys following the alpha split.

A-K is sent to Agency B (BD)

L-Z is sent to Agency A (BD)

- Pre-listed accounts are reviewed by the Team Leader for the appropriate referral and transfer of these accounts to BD status.

Collection Process

Accounts are received electronically or manually and loaded for pre-process scrubbing. Data is analyzed, corrected if needed, and approved.

Prior to any collection activity, the confirmation process begins with each account scrubbed for the following information:

- valid ss#
- deceased (if found, probate scrub)
- bankruptcy (if found prior to dos, cancel)
- recovery score (based on the overall credit file and the consumers ability to pay)
- newer address or phone numbers than provided by the creditor (this is added to the file but does not replace what the client turned over to us.)

The data is updated to the collection system and accounts will receive the standard collection notices. The first notice (Validation) is mailed to the debtor.

Accounts with telephone numbers are loaded to the dialer and collection calls begin.

The second collection notice (Credit Default) is mailed to the debtor. The notice states that the account may be sent to all three credit bureaus: Trans Union, Experian, and Equifax.

The third collection notice (Credit Bureau Notification) is mailed to the debtor. The notice states that the account may have been sent to all three credit bureaus.

Collection calls continue.

The fourth notice (Legal Review) is mailed to the debtor. The notice states that the account may be reviewed for further action.

Collection calls continue.

- Both Medicare and non-Medicare accounts are to be returned to the hospital from the external collection agencies, identified as uncollectible to be written off to bad debt uncollectible after a period of (1) year when the agencies have not been able to contact the patient, the patient has not responded or the patient is deemed judgment proof. The agencies should return the Medicare and non-Medicare account in separate files identified with a transaction code for reporting purposes

Collection Attorneys

- Patient Accounts are reviewed and approved by the Manager of Patient Business Services for direct referral to the collection attorneys.
- Accounts are directly referred to attorneys in cases where we have identified circumstances where legal proceedings will be eminent and the routine collection agency time frames or procedures would not be effective
- The Stamford Hospital will, when appropriate, utilize property liens, wage executions, payment contracts and bank executions for accounts entered into judgment and granted by the courts.

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

The Stamford Hospital

Subject: Stamford Hospital Financial Assistance Prenatal Program (FAPPNP)

Policy # 0015

Implemented: 10/01/08

Reference(s):

Revisions: 06/05/12, 11/27/2013

Approval: EM, CR

Reviewed 10/01/09

Department: Patient Business Services

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Purpose

Stamford Hospital Financial Assistance Prenatal Program Policy.

Effective date 10/01/2008

Policy

I. Stamford Hospital is committed to provide financial assistance to patients seeking prenatal care utilizing a fixed fee payment program. Service provided beyond this program will be processed through the Hospital Financial Assistance Program.

II. Procedure

1. Women who present themselves for prenatal care and a determined to be eligible for financial assistance will be offered the prenatal program. This program does not provide coverage for the delivery or newborn care.
2. Eligibility for financial assistance is based upon financial need.
 - a. Stamford Hospital will use a sliding scale based on multiples of the Federal Poverty Guidelines to determine the percent of financial assistance granted.
 - b. Stamford Hospital will consider available assets. Available assets do not include the patient's primary residence or automobiles needed for regular transportation.
3. Patients are asked to provide supporting documentation to authorize representatives to assist them in determining eligibility for Financial Assistance Programs Prenatal (FAPPN).
4. Applications must be initially approved by one of the following authorized employees: Optimus Financial Counselors, Stamford Hospital Financial Assistance Counselors, Stamford Hospital Patient Assistance Coordinator and designated Management personnel within The Patient Business Services Department.

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

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

To apply for financial assistance, an application for this program should be completed and submitted to the Patient Business Services office together with supporting documents. Applications for financial assistance programs (FAP) are provided to patients by the Public Assistance Coordinator, Financial Counselors, Social Workers, Patient Access Representative and Customer Service Representatives. Social Services, Case Management and other hospital departments refer patients to the Public Assistance Coordinator or the Financial Counselors for screenings. The application and supporting documents are generally required to determine eligibility for financial assistance, and will be considered at any time.

Stamford Hospital

Subject: Stamford Hospital Financial Assistance Program

Policy # 0016

Implemented: 10/01/08

Reference(s):

Revisions: 06/05/12,11/27/2013

Approval: EM, CR

Reviewed

Department: Patient Business Services

Page: 1 of 2

Purpose

Stamford Hospital Financial Assistance Program Policy

Effective Date: October 1, 2008

Stamford Hospital Financial Assistance Program Policy

I. POLICY:

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

II. PROCEDURE:

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

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

3. There are instances when a patient may appear eligible for financial assistance but there is no application on file due to a lack of supporting documentation. Under these circumstances financial assistance may be granted. These situations include but are not limited to:
 - a. Homeless individuals with a Shelter address or unknown address where there is no means of contact after service rendered.
 - b. Deceased patients where it has been determined that there is no open estate or that the estate is insolvent;
 - c. Other situations on a case by case basis at Stamford Hospital's discretion

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

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

To apply for financial assistance, an application for this program should be completed and submitted to the Patient Business Services office together with supporting documents. Applications for financial assistance programs (FAP) are provided to patients by the Public Assistance Coordinator, Financial Counselors, Social Workers, Patient Access Representative and Customer Service Representatives. Social Services, Case Management and other hospital departments refer patients to the Public Assistance Coordinator or the Financial Counselors for screenings. The application and supporting documents are generally required to determine eligibility for financial assistance, and will be considered at any time.

TSH FINANCIAL ASSISTANCE CALCULATION TABLE
Based on Federal Poverty Guidelines Effective 02/2015

A	B	C	D		E		F		G	
			FAP-Level 0 100%	FAP-Level 1 90%	FAP-Level 2 80%	FAP-Level 3 70%	FAP-Level 4 60%			
	Family Unit Size	FEDERAL Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)			
Income Per Year	1	\$11,770	\$23,540	\$29,425	\$35,310	\$41,195	\$47,080			
Income Per Year	2	\$15,930	\$31,860	\$39,825	\$47,790	\$55,755	\$63,720			
Income Per Year	3	\$20,090	\$40,180	\$50,225	\$60,270	\$70,315	\$80,360			
Income Per Year	4	\$24,250	\$48,500	\$60,625	\$72,750	\$84,875	\$97,000			
Income Per Year	5	\$28,410	\$56,820	\$71,025	\$85,230	\$99,435	\$113,640			
Income Per Year	6	\$32,570	\$65,140	\$81,425	\$97,710	\$113,995	\$130,290			
Income Per Year	7	\$36,730	\$73,460	\$91,825	\$110,190	\$128,555	\$146,920			
Income Per Year	8	\$40,890	\$81,780	\$102,225	\$122,670	\$143,115	\$163,560			
	Each addit.: Add	\$4,160								
			FAP-Level 0 100%	FAP-Level 1 90%	FAP-Level 2 80%	FAP-Level 3 70%	FAP-Level 4 60%			
	Family Unit Size	FEDERAL Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)			
Income Per Month	1	\$981	\$1,962	\$2,452	\$2,943	\$3,433	\$3,923			
Income Per Month	2	\$1,328	\$2,655	\$3,319	\$3,983	\$4,646	\$5,310			
Income Per Month	3	\$1,674	\$3,348	\$4,165	\$5,023	\$5,880	\$6,697			
Income Per Month	4	\$2,021	\$4,042	\$5,052	\$6,063	\$7,073	\$8,083			
Income Per Month	5	\$2,368	\$4,735	\$5,919	\$7,103	\$8,286	\$9,470			
Income Per Month	6	\$2,714	\$5,428	\$6,785	\$8,143	\$9,500	\$10,857			
Income Per Month	7	\$3,061	\$6,122	\$7,652	\$9,183	\$10,713	\$12,243			
Income Per Month	8	\$3,408	\$6,815	\$8,519	\$10,223	\$11,926	\$13,630			
	Each addit.: Add	\$346.67								
			FAP-Level 0 100%	FAP-Level 1 90%	FAP-Level 2 80%	FAP-Level 3 70%	FAP-Level 4 60%			
	Family Unit Size	FEDERAL Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)			
Income Per Week	1	\$226	\$453	\$566	\$679	\$792	\$905			
Income Per Week	2	\$306	\$613	\$766	\$919	\$1,072	\$1,225			
Income Per Week	3	\$386	\$773	\$966	\$1,159	\$1,352	\$1,545			
Income Per Week	4	\$466	\$933	\$1,168	\$1,399	\$1,632	\$1,865			
Income Per Week	5	\$546	\$1,093	\$1,366	\$1,639	\$1,912	\$2,185			
Income Per Week	6	\$626	\$1,253	\$1,566	\$1,879	\$2,192	\$2,505			
Income Per Week	7	\$706	\$1,413	\$1,766	\$2,119	\$2,472	\$2,825			
Income Per Week	8	\$786	\$1,573	\$1,966	\$2,359	\$2,752	\$3,145			
	Each addit.: Add	\$80.00								

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

- Level 0
 - 100% adjustment to patient's account balance*
 - * Self pay patients are asked to pay what they can afford prior to or at the time of service. Amounts collected prior to, or at the time of service are not refundable.
- Level 1
 - 90% adjustment to patient's account balance. Patient is responsible for paying 10% of the remaining balance
- Level 2
 - 80% adjustment to patient's account balance. Patient is responsible for paying 20% of the remaining balance
- Level 3
 - 70% adjustment to patient's account balance. Patient is responsible for paying 30% of the remaining balance
- Level 4
 - 60% adjustment to patient's account balance. Patient is responsible for paying 40% of the remaining balance
- Income
 - Financial Assistance (FAP) applications may be accepted and considered for inpatient and outpatient services. Applications for financial assistance will require verifiable proof of income and/or assets (i.e., W-2 forms, tax return, payroll check stubs, statements from employer, bank records, tax records, self employment disclosure, etc. All other avenues to obtain financial assistance and third party payment must be exhausted prior to receiving financial assistance. A determination may require screening for a Qualified Health Plan (QHP) or Husky eligibility through Access Health CT or other States' programs. Assets
 - The applicant's primary residence and primary vehicle will be exempt from inclusion of assets.
 - Any additional real and personal property may be used in the evaluation in determining financial assistance.
 - The amount of cash in savings and checking accounts will also be used in determining financial assistance.
 - It is the responsibility of the applicant to provide, upon request, adequate documentation of checking/savings accounts. Acceptable documentation will consist of current bankbooks or statements.

TSH FINANCIAL ASSISTANCE CALCULATION TABLE
Based on Federal Poverty Guidelines Effective 02/2014

A		B		C		D		E		F		G	
		FAP-Level 0		FAP-Level 1		FAP-Level 2		FAP-Level 3		FAP-Level 4		FAP-Level 4	
		100%		80%		60%		70%		80%		60%	
FEDERAL													
Family Unit Size		Poverty Guidelines											
1		(X2)	(X2.5)	(X3)	(X3.5)	(X4)	(X4)	(X4)	(X4)	(X4)	(X4)	(X4)	(X4)
Income Per Year		\$11,670	\$23,340	\$29,175	\$35,010	\$40,845	\$46,680	\$46,680	\$46,680	\$46,680	\$46,680	\$46,680	\$46,680
Income Per Month		\$973	\$1,945	\$2,431	\$2,918	\$3,404	\$3,890	\$3,890	\$3,890	\$3,890	\$3,890	\$3,890	\$3,890
Income Per Week		\$224	\$561	\$581	\$703	\$815	\$927	\$927	\$927	\$927	\$927	\$927	\$927
Income Per Year	2	\$15,730	\$31,460	\$39,325	\$47,190	\$55,055	\$62,920	\$62,920	\$62,920	\$62,920	\$62,920	\$62,920	\$62,920
Income Per Month		\$1,311	\$2,622	\$3,277	\$3,933	\$4,588	\$5,243	\$5,243	\$5,243	\$5,243	\$5,243	\$5,243	\$5,243
Income Per Week		\$381	\$951	\$991	\$1,147	\$1,332	\$1,522	\$1,522	\$1,522	\$1,522	\$1,522	\$1,522	\$1,522
Income Per Year	3	\$19,790	\$39,580	\$49,475	\$59,370	\$69,265	\$79,160	\$79,160	\$79,160	\$79,160	\$79,160	\$79,160	\$79,160
Income Per Month		\$1,649	\$3,298	\$4,123	\$4,948	\$5,772	\$6,597	\$6,597	\$6,597	\$6,597	\$6,597	\$6,597	\$6,597
Income Per Week		\$459	\$917	\$969	\$1,172	\$1,363	\$1,553	\$1,553	\$1,553	\$1,553	\$1,553	\$1,553	\$1,553
Income Per Year	4	\$23,850	\$47,700	\$59,625	\$71,550	\$83,475	\$95,400	\$95,400	\$95,400	\$95,400	\$95,400	\$95,400	\$95,400
Income Per Month		\$2,326	\$4,652	\$5,815	\$6,978	\$8,140	\$9,303	\$9,303	\$9,303	\$9,303	\$9,303	\$9,303	\$9,303
Income Per Week		\$615	\$1,230	\$1,457	\$1,742	\$2,027	\$2,312	\$2,312	\$2,312	\$2,312	\$2,312	\$2,312	\$2,312
Income Per Year	5	\$27,910	\$55,820	\$69,775	\$83,730	\$97,685	\$111,640	\$111,640	\$111,640	\$111,640	\$111,640	\$111,640	\$111,640
Income Per Month		\$3,003	\$6,003	\$7,478	\$8,953	\$10,428	\$11,903	\$11,903	\$11,903	\$11,903	\$11,903	\$11,903	\$11,903
Income Per Week		\$771	\$1,542	\$1,869	\$2,231	\$2,617	\$2,979	\$2,979	\$2,979	\$2,979	\$2,979	\$2,979	\$2,979
Income Per Year	6	\$36,030	\$72,060	\$90,075	\$108,090	\$126,105	\$144,120	\$144,120	\$144,120	\$144,120	\$144,120	\$144,120	\$144,120
Income Per Month		\$3,003	\$6,005	\$7,506	\$9,007	\$10,508	\$12,009	\$12,009	\$12,009	\$12,009	\$12,009	\$12,009	\$12,009
Income Per Week		\$771	\$1,542	\$1,877	\$2,252	\$2,627	\$3,002	\$3,002	\$3,002	\$3,002	\$3,002	\$3,002	\$3,002
Income Per Year	7	\$40,090	\$80,180	\$100,225	\$120,270	\$140,315	\$160,360	\$160,360	\$160,360	\$160,360	\$160,360	\$160,360	\$160,360
Income Per Month		\$3,341	\$6,682	\$8,352	\$10,023	\$11,693	\$13,363	\$13,363	\$13,363	\$13,363	\$13,363	\$13,363	\$13,363
Income Per Week		\$833	\$1,666	\$2,088	\$2,511	\$2,933	\$3,356	\$3,356	\$3,356	\$3,356	\$3,356	\$3,356	\$3,356
Income Per Year	8	\$44,150	\$88,300	\$110,375	\$132,450	\$154,525	\$176,600	\$176,600	\$176,600	\$176,600	\$176,600	\$176,600	\$176,600
Income Per Month		\$3,679	\$7,358	\$9,197	\$11,036	\$12,875	\$14,714	\$14,714	\$14,714	\$14,714	\$14,714	\$14,714	\$14,714
Income Per Week		\$919	\$1,838	\$2,299	\$2,759	\$3,220	\$3,680	\$3,680	\$3,680	\$3,680	\$3,680	\$3,680	\$3,680
Income Per Year	Each addit.: Add		\$4,060		\$10,150		\$25,375		\$63,437		\$158,592		\$396,480

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

- Level 0: 100% adjustment to patient's account balance*
 - * Self pay patients are asked to pay what they can afford prior to or at the time of service. Amounts collected prior to, or at the time of service are not refundable.
 - Level 1: 90% adjustment to patient's account balance. Patient is responsible for paying 10% of the remaining balance
 - Level 2: 80% adjustment to patient's account balance. Patient is responsible for paying 20% of the remaining balance
 - Level 3: 70% adjustment to patient's account balance. Patient is responsible for paying 30% of the remaining balance
 - Level 4: 60% adjustment to patient's account balance. Patient is responsible for paying 40% of the remaining balance
- Income: Financial Assistance (FAP) applications may be accepted and considered for inpatient and outpatient services. Applications for financial assistance will require verifiable proof of income and/or assets (i.e., W-2 forms, tax return, payroll check stubs, statements from employer, bank records, tax records, self employment disclosure, etc. All other avenues to obtain financial assistance and third party payment must be exhausted prior to receiving financial assistance. A determination may require screening for a Qualified Health Plan (QHP) or Husky eligibility through Access Health CT or other States' programs. Assets: The applicant's primary residence and primary vehicle will be exempt from inclusion of assets. Any additional real and personal property may be used in the evaluation in determining financial assistance. The amount of cash in savings and checking accounts will also be used in determining financial assistance. It is the responsibility of the applicant to provide, upon request, adequate documentation of checking/savings accounts. Acceptable documentation will consist of current bankbooks or statements.



MR# _____

FAP Pre-natal FAP

Solicitud de Asistencia Financiera
Complete todo lo que le aplique

Fecha: ____/____/____

Información del Paciente:

Apellido: _____ Primer Nombre: _____

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

Dirección: _____ # de Apt: _____

Ciudad: _____ Estado: _____ Código Postal: _____

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

Empleo: _____

Dirección del Empleo: _____

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

Numero de Seguro Social: ____-____-____

Empleo de la persona responsable: _____

Teléfono del empleo: (____) _____

Dirección del empleo: _____

Personas a su cargo:

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



Favor de proveer copias de los documentos disponible en la lista de documentos. Favor de traer los documentos antes de 15 días del día que se le fue dado el formulario. Toda la información sometida por escrito, verbal o gravada en relación con el formulario es confidencial. Si tiene preguntas o necesita mas información por favor llamar a un Consejero(a) Financiero(a) al numero (203) 276-7515 o (203) 276-4831 en el Departamento de Servicios al Paciente.

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

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

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

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

USO DEL HOSPITAL DE STAMFORD

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

Razón para ser negada: _____

Asistencia Financiera Aprobada: _____ @ _____ %Negada _____

Razón por ser negada: _____ Fecha _____

Procesador: _____ Fecha _____

Suma ajustada: \$ _____ Código: _____

Prosesador: _____ Fecha: _____

Formulario recibido por: _____



STAMFORD HOSPITAL | Discover More
The Regional Center for Health

Affiliate of Columbia University - College of Physicians & Surgeons
Member Newark-Presbyterian Healthcare System
A Planetree Hospital

MR# _____

FAP Pre-natal FAP

Financial Assistance Application
Complete all applicable items

Date of Request: ___/___/___

Patient information:

Last name: _____ First Name _____ Middle Initial _____

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

Address: _____ Apt # _____

City: _____ State: _____ Zip code: _____

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

Employer: _____

Employer's address: _____

Person Responsible for the bill: _____

Social Security Number: _____-_____-_____

Employer of person responsible for the bill: _____

Employer's telephone # (____) _____

Employer's address: _____

Dependents in household:

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



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The Regional Center for Health

Medical Center, University of Medicine & Dentistry
At the University of Medicine & Dentistry
At the University of Medicine & Dentistry

Please provide copies of available documents on the attached list of Documentation and Verification Forms. Patients are to provide this information within 15 days of receiving the application. All information provided, discussed or recorded in relation to this application is confidential. If you have questions or require further assistance contact a Financial Assistance Counselor at (203) 276-7515 or (203) 276-4831 at the Patient Business Department.

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

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

Applicant's Signature: _____

Date: _____

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

FOR HOSPITAL USE ONLY

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

Reason for Denial: _____

Financial Assistance Approved: _____ @ _____ % Denied: _____

Reason for Denial: _____ Date: _____

By: _____ Date: _____

Amount of Adjustments: \$ _____ Code: _____

Completed by: _____ Date: _____

Form Taken By: _____



Documentation and Verification Forms

Please provide applicable documents listed below for applicant/spouse or significant other and children (if applicant is a minor provide parents information) to your Financial Assistance Counselor or the Patient Business Services Department.

PLEASE PROVIDE US WITH COPIES OF THE FOLLOWING DOCUMENTATION

Insurance:

- | | | | |
|--------------|---|-----------|---|
| Health | <input type="checkbox"/> YES or <input type="checkbox"/> NO | Liability | <input type="checkbox"/> YES or <input type="checkbox"/> NO |
| Workers comp | <input type="checkbox"/> YES or <input type="checkbox"/> NO | MVA | <input type="checkbox"/> YES or <input type="checkbox"/> NO |

Federal and State Benefits:

- Department of Social Services Denial Letter
- Food Stamps/Cash Assistance Letter
- Department of Social Services Medical (Medicaid) coverage
- Social Security Benefits Letter

Identification:

- Photo ID / Passport / Permanent Resident Card
- Proof of Address (utility bills, cable, telephone)
- Children's Birth Certificate

Income:

- Most Recent Tax Return and W-2 or 1099
- Pay Stubs for last month (4 weekly / 2 bi-weekly)
- Notarized letter from employer or self
- Unemployment payment History
- If unemployed please provide a notarized letter indicating how you support yourself.
- Alimony and Child Support

Assets:

- Most recent Bank Account Statement (Checkings, Savings, CD's, 401K, 403B)
 YES or NO if no, please initial _____
- Do you own Property other than the primary residence?
 YES or NO if yes, rental income \$ _____

Residence Information:

- Rent Receipt / Mortgage Statement
- Notarized letter from landlord or self
- Shelter letter

Pre-natal:

- Pre-natal contract (Optimus/TSH contract)

ARE YOU UNINSURED?

If you meet the definition "uninsured" as defined by Section 19a-673 of the Connecticut General Statutes, you may be eligible for Hospital, "bed funds" or Financial Assistance. You are "uninsured" if you meet all of the following:

You have one or more outstanding balances due to Stamford Hospital.

You have applied and been denied for any medical or health care coverage provided under Medicaid or Limited Income Adults (LIA). Proof of denial is required.

You are not eligible for coverage for hospital services under any other health or accident insurance program (including workers' compensation, third party liability, or motor vehicle insurance).

Your household income is at or below 250% of the Federal Poverty Guidelines. Proof of income is required.

To find out if you qualify, please contact us. We are also available to assist you with the Medicaid/LIA application process and other Stamford Hospital Financial Assistance Programs. Please contact us at the following location.

**Stamford Hospital, Customer Service Department,
 1351 Washington Blvd. 7th Floor, Stamford, CT 06904-9317
 Telephone: 203-276-7572, 9:00am - 5:00pm, Monday-Friday**

2015 FEDERAL POVERTY GUIDELINES	
FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Size of family unit	Poverty Guidelines
1	\$11,770.00
2	\$15,930.00
3	\$20,090.00
4	\$24,250.00
5	\$28,410.00
6	\$32,570.00
7	\$36,730.00
8	\$40,890.00

For family units more than 8 members, add \$4,160 for each additional member. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)

¿NO TIENE SEGURO MEDICO?

Si usted satisface la definición de "no asegurado" según consta en la sección 19a-673 de los estatutos generales del estado de Connecticut, usted puede ser eligible para obtener asistencia. Financiera o fondos de cama si cumple con los siguientes requisitos:

- Usted tiene uno o mas saldos pendientes de pago con el Hospital de Stamford.
- Usted ha solicitado cualquier cobertura de seguro medico o de cuidado de la salud suministrada por Medicaid o ("LIA") ha sido rechazado por no satisfacer los requisitos de ingresos u otros.
 - Se requiere prueba del rechazo.
- No tiene derecho a ningún seguro que cubra los servicios de hospitales debajo de ningún otro programa de seguro de salud o de accidentes (esto incluye la compensación de obreros, seguro de automóvil o responsabilidad de terceros.)
- El ingreso de su familia equivale al 250% de las Directrices Federales de Ingreso de Pobreza, o menos.
 - Se requiere prueba de ingresos.

Llámenos para saber si usted llena los requisitos. También le podremos ayudar con el proceso de solicitud de Medicaid y LIA. Puede Comunicarse con nosotros en una de las siguiente oficinas.

**Stamford Hospital, Departamento del, Servicio al Cliente,
1351 Washington Blvd. 7th Floor, Stamford, CT 06904-9317
Teléfono: 203-276-7572, 9:00 a.m. - 5:00 p.m., Lunes a Viernes**

2015 GUÍA FEDERAL DE POBREZA	
PARA LOS 48 ESTADOS CONTINGUOS Y EL DISTRITO DE COLUMBIA	
Tamaño de la unidad familiar	Guías de pobreza
1	\$11,770.00
2	\$15,930.00
3	\$20,090.00
4	\$24,250.00
5	\$28,410.00
6	\$32,570.00
7	\$36,730.00
8	\$40,890.00

Para las unidades familiares de más de 8 miembros, agregue \$ 4,160 por cada miembro adicional. (El mismo incremento se aplica a los tamaños más pequeños de la familia también, como puede verse en las figuras anteriores.)



Affiliate Columbia University-College of Physicians & Surgeons
Member New York-Presbyterian Healthcare System
A Plandome Hospital

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

PATIENT NOTICE ON FINANCIAL ASSISTANCE

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

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

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

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

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

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

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

Aviso Al Publico

Fondos para cama del hospital
le podrian ayudar con su
tratamiento.

El hospital de Stamford
tambien ofrece otras ayudas
financieras basada en su
abilidad de pago.

Para solicitar, por favor
contactar al departamento de
servicios al clientes.

203-276-7572.

Public Notice

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

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

To apply, please contact the Customer Service Department at 203-276-7572.

The Stamford Hospital

Subject: Hospital Bed Funds Policy and Procedures

Policy # 018

Implemented: 05/31/07

Reference(s):

Revisions: 09/15/10

Approval: EM

Reviewed: 02/18/2014

Department: Patient Business Services

Page: 1 of 4

Purpose

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

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

DEFINITIONS

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

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

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

Policy

OBJECTIVE OF POLICY

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

STATEMENT OF POLICY

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

PROCEDURES

1. The Hospital shall at all times cause to be posted the public notice (“Notice”) attached hereto at Exhibit A regarding the availability of Hospital Bed Funds. The Notice shall be posted in English and Spanish in conspicuous places in each patient admitting location of the Hospital including, but not limited to, the admissions offices, emergency room, social services department and patient accounts/billing offices.
2. The Hospital shall also make available the one page summary (“Summary”) attached hereto at Exhibit B describing Hospital Bed Funds and how to apply for them. The Summary shall be available in various locations throughout the Hospital, including, but not limited to, the admissions offices, emergency room, social services department and patient accounts/billing offices. The Summary shall also be available from any Collection Agent and provided directly to patients if during the admission process or during the review of the financial resources of the patient, patient registration personnel, financial counselors or other employees of the Hospital believe the patient will have limited funds to pay for any portion of the patient’s hospitalization not covered by insurance. In addition, the Summary shall be included in all bills and collection notices sent by Collection Agents.
3. The Hospital will provide training to all relevant staff, including, but not limited to, its financial counselors, social workers, discharge planners and billing personnel concerning the existence of Hospital Bed Funds, eligibility requirements and the procedures for application. This training program shall be overseen by the Patient Access Business Services Department.
4. Patients applying for Hospital Bed Funds shall be furnished with the application form (“Application”) attached hereto at Exhibit C. Financial counselors in the Patient Registration Department shall assist Hospital inpatients with the Application process while financial counselors assigned to the Hospital’s ambulatory clinics and Customer Service Department shall perform the same function for outpatients and/or post-discharge patients seeking to apply. All patients, including, but not limited to, Medicare and Medicaid beneficiaries seeking relief from cost-sharing amounts, shall be permitted to apply for Hospital Bed Funds at any time during or after their hospital stay or outpatient visit.
5. The Hospital’s Finance Department, working in collaboration with the Stamford Health Foundation (“SHF”), shall keep a listing of all Hospital Bed Funds that are available to Eligible Patients. This listing shall contain the names of all Funds, an internally assigned account number and set forth all relevant eligibility criteria and restrictions concerning use of the Funds. The listing shall be updated periodically to reflect available Funds and current Fund balances, and be distributed to the following personnel: Chief Financial Officer, Senior Vice President of SHF, Executive Director of Finance, Executive Director of Patient Access Business Services, Manager of Patient Access Business Services, Director of Clinical Compliance, Public Assistance Coordinator and all financial counselors involved in the Application process.

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

6. The documentation and verification requirements for determining whether an applicant will be deemed an Eligible Patient for purposes of receiving any Hospital Bed Funds that may be available shall be based on the criteria established by the Fund donor or, to the extent such criteria is not provided or not applicable for any reason, by the applicant providing the information required under the Hospital's Financial Assistance Program ("FAP") to demonstrate financial need. Once the applicant is deemed an Eligible Patient, the Patient Access Business Services Department shall determine the amount to be granted from any available Hospital Bed Funds based on the parameters established by the Funds or, if none exist, the particular facts and circumstances of the case. Stamford Hospital may have potential applicants referred to them from the Optimus Clinics, Stamford Hospital Sub-specialty Clinics, Social Services Department Patient Assistance Co-ordinator, Financial Counselors and Customer Service Staff. A check request should be completed prior to final approval. The payment(s) to be applied from the appropriate bed fund(s) to qualifying accounts will be calculated using the latest available published acute care hospital ratios of costs to charges. The difference will be adjusted to an Administrative Free Bed Fund write off code.

7. In distributing Hospital Bed Funds, the Director of Revenue Cycle shall have authority to grant amounts up to \$5,000. Awards that exceed \$5,000 but are less than \$25,000 shall require the approval of the Executive Director of Reimbursement & Revenue Cycle while awards of \$25,000 and above shall require the approval of the Chief Financial Officer. The amounts awarded shall be applied against the Eligible Patient's outstanding bill and shall not be paid directly to any individual.

Grants provided to Stamford Hospital include the Patient Care Fund, M. Dolittle Income and William Pitt FMC Funds.

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

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

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

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

Reconciliation to Patient's Account:

Once the check request has been granted and the check is cut, Cash Applications will post the payment, using the Meditech Procedure Code PSPFB. The remaining balance is then to be adjusted off using procedure code AADMINFBB.