

THE WILLIAM W. BACKUS HOSPITAL
Patient Business Services Policy

Subject:	Bad Debt Write Offs
Date:	01/19/04
Revision Date:	06/06/06

Policy: It is the policy of William W. Backus Hospital that uncollected self-pay accounts more than 120 days old will be written off and sent to a collection agency.

Procedure:

- I Self Pay Accounts Collection Process
 - A Initial letter is sent 5 days after discharge.
 - B Statement #1 is sent 30 days later.
 - C Statement # 2 is sent 30 days later.
 - D Precollect Letter is sent 15 days later (by Medconn).
 - E Account will be written off to bad debt 45 days later.
- II Self Pay balances after insurance
 - A Statement # 1 is sent 15 day after account goes to self pay.
 - B Statement # 2 is sent 30 days later.
 - C Statement # 3 is sent 21 days later.
 - D Precollect Letter is sent 21 days later.
 - E Account will be written off to bad debt 45 days later.
- III Weekly Bad Debt Transfer Process
 - A On Monday the bad debts file are created.
 - zBD PRE COLL
 - zBD XSP
 - B The preliminary report is reviewed for the following:
 - 1 Accounts with payments made in the last 30 days. If time permits, the staff will attempt to contact the patient to attempt to set up an approved payment contract for the account.
 - a. If an approved payment contract is established, the account will be removed from the bad debt file.
 - 2 Accounts with balances of \$1000 or more. If time permits the staff will attempt to contact the patient to attempt to determine if they may qualify for free bed funds, charity care or a payment contract.
 - a. If the patient may qualify, and application is sent and the account is not sent to bad debt, pending a response within 14 days. If no response is received the account will be sent to bad debt in the next weekly processing cycle.
 - b. The account will be placed on "Bad Debt Hold". A note is placed on the account indicating the application for free bed and charity care.
 - c. A reminder will be set up to review the account in 14 days. If the application is received the hold will be removed and the

account will be processed according to the free bed/charity care policy. If the patient does not qualify, the hold will be removed and the account will go to bad debt in the next weekly processing cycle. If the application is not received back in 14 days the hold will be removed and the account will go to bad debt in the next weekly processing cycle.

- 3 Accounts with balances of \$1000 or more. If time permits the staff will attempt to process the accounts through Passport One to determine if Medicaid coverage has been established for the patient. If so, the account will be updated and Medicaid billed.

C On Friday of the same week, MIS will be contacted to send the file to the collection agency. Files will be received by the collection agency by the close of business every Friday.

IV Processing the Weekly Bad Debt Write Off

A The procedures used to process the Weekly Bad Debt write off are found:
Under the Collections button,
Bad Debt

Automatic Bad Debt Transfer

B The processes to use and their functions are:

- 1 Compile – this is run on Monday to create the file of accounts that may be written off to bad debt
- 2 Print – once the file has compiled, this report is run to use to review the accounts as outlined above.
- 3 Process -
- 4 Transfer

THE WILLIAM W. BACKUS HOSPITAL
Patient Business Services Policy

Subject:	Charity Care Financial Assistance
Origination Date:	10-01-2003
Revision Date:	

Policy: It is the policy of The William W. Backus Hospital that medically necessary health care services should be available to all individuals, regardless of their ability to pay.
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Procedure:

- I Eligibility Criteria
 - A Patient Accounting staff is available to help patients apply for charity care.
 - B Full charity care usually will be provided to a responsible party with gross family income at or below 250% of Federal Poverty Guidelines (FPG).
 - C A sliding-fee scale will be used to determine charity care discounts when gross family income is above 250% of FBG.
 - D Notification of charity care determinations will be mailed to the responsible party. Reasonable payment arrangements consistent with the responsible party's ability to pay will be extended for amounts owed.
- II Notification to Patient's
 - A Signage indicating the availability of charity care will be posted in English and Spanish in Patient Accounts. Admitting, Social Services and the Emergency Department. Summaries of the programs will also be available in those areas.
 - B Financial Counselors will attempt to visit all inpatients registered as self pay patients. A summary explaining charity care will be given to the patient when this visit occurs.
 - C Patients with not insurance will receive an initial letter within one week of discharge informing them that the hospital considers them "insured" per the Connecticut General Statutes Section 19a-673. It is the responsibility of the patient to advise the hospital if they believe they qualify as "uninsured" (at or under 250% of the FPG).
 - D A collection cycle of four monthly statements will then be sent. Each statement will remind the patient of the availability of charity care.
 - E A second letter will then be sent to the patient once again informing them that the hospital considers them "insured" per the Connecticut General Statutes Section 19a-673. It is the responsibility of the patient to advise the hospital if they believe they qualify as "uninsured".
- III Gross Family Income
 - A For the purposes of determining gross family income and qualifying accounts for free bed funds and charity care, the following rules apply:

- 1 Family members are only immediate family members, which includes applicant, spouse, and children under the age of 18 and stepchildren under the age of 18. Other family relations will not be considered.
- 2 Unmarried couples do not qualify as a family. Only the applicant's income will be looked at for qualification for funds and only the applicant's accounts will be awarded free bed or charity care funds if qualified.

IV Eligibility Determinations

- A The provision of health care should never be delayed pending an assistance determination.
- B Requests for charity care may be made at any point before, during or after the provision of care.
- C Charity care requests may be proposed by sources other than the patient, groups, social services or hospital personnel.
- D Consideration for charity care will occur once the applicant supplies a completed Financial Assistance Application with supporting documents to the Patient Accounts office.
- E The William W. Backus Hospital will make every attempt to make charity care determinations within 20 days of receiving a completed Financial Assistance Application.
- F Acceptable verification of income includes the following
 - 1 Most recent federal tax return or W-2
 - 2 Recent payroll check stub or any verification of income
 - 3 Copies of any pension, alimony or other sources of income
 - 4 Copies of Social Security earnings if applicable
 - 5 Any other information that may be pertinent
- G Charity care may be denied if the application is not completed and returned to The William W. Backus Hospital Patient Accounts Department within 20 days of receipt by the responsible party.
- H Charity care will not be considered without a completed Financial Assistance application unless sufficient like information can be obtained that allows for a final determination without an application. In extenuating circumstances, where it can support a financial hardship exists, The William W. Backus Hospital may offer charity care at its own determination.
- I Charity care may not be granted for some procedures, such as elective cosmetic surgery or some special situations, such as that of an individual who is eligible for insurance but has refused to apply.
- J Falsification of application or refusal to cooperate will result in the denial of charity care benefits. The patient will be deemed "insured" and will be transferred to the self-pay collection process.
- K Applications will remain in effect for 1 year. If there have been considerable changes to the applicant's status during that time a new application may be requested.
- L The William W. Backus Hospital reserves the right to change benefit determination if financial circumstances change.

V

Appeals

Responsible parties may appeal a charity care determination by providing additional information, such as insurance verification or an explanation of extenuating circumstances to Patient Accounts within 30 days of receiving notification of the appeals outcome. Collection follow-up on account balances will be pended during the appeal process.



Federal Poverty Guidelines
Effective January 23, 2009

Size of Family	Poverty Guideline	250% FPG	275% FPG	300% FPG	325% FPG
		100% awarded	75% awarded	50% awarded	25% awarded
1	10,830	27,075	29,783	32,490	35,198
2	14,570	36,425	40,068	43,710	47,353
3	18,310	45,775	50,353	54,930	59,508
4	22,050	55,125	60,638	66,150	71,663
5	25,790	64,475	70,923	77,370	83,818
6	29,530	73,825	81,208	88,590	95,973
7	33,270	83,175	91,493	99,810	108,128
8	37,010	92,525	101,778	111,030	120,283

For families with more than 8 members, add 9,350. for each additional member.

APPLICATION FOR FREE BED AND CHARITY CARE FUNDS

I hereby request that the William W. Backus Hospital make a written determination of my eligibility for Free Bed and/or Charity Care Funds. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by the William W. Backus Hospital. I, also, understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services as uncompensated services and that I will be liable for charges of services provided.

1. NAME:

Address: _____
 Phone: _____
 Occupation: _____
 Employer: _____
 Employer's Address: _____

2. INCOME:

Wages: _____
 Farm or Self-Employed: _____
 Public Assistance: _____
 Social Security: _____
 Unemployment Compensation: _____
 Strike Benefits: _____
 Alimony: _____
 Child Support: _____
 Military Family Allotments: _____
 Pensions: _____
 Income from Dividends, Interest, Rent: _____

3. Number of family members:

NAME:	RELATIONSHIP:	AGE:

4. Originating Account Number: _____

I affirm that the information given is true and correct to the best of my knowledge. I authorize the release of this information if it is requested, as outlined by Federal Guidelines.

Date: _____ **Signature:** _____