

Attachment A
 State of Connecticut – Medical Assistance Programs

Qualifications for eligibility

Medicaid

You must be disabled or legally blind, 65 years old or more, under 21 years of age or pregnant and families with children. You must meet income and asset limits. Income limits vary, depending on the size of your family.

Saga

This program provides medical assistance to eligible individuals who do not have enough money to meet their basic needs and are unable to work because of illness or another reason. Eligibility is based on income and assets only. Persons receiving GA cash assistance are automatically eligible.

Healthy Start

This program covers health services to low-income pregnant women and will cover prenatal care and delivery for permanent residents/citizens and delivery only for undocumented aliens.

Emergency Medical – Medicaid

This program provides medical assistance to illegal aliens if:

- they are categorically eligible, which means they need to fit into one of the Title 19 categories, e.g., aged, blind, disabled, or a dependent child. Pregnant women are also considered categorically eligible.
- Second, the reason for their admission to the hospital needs to be life-threatening emergency. What this means is that had the hospital not admitted and treated the person immediately in all likelihood the person would have died. In this case the patient does not necessarily have to be determined disabled to qualify.

Family Size	Monthly Income Limits for Medicaid & Saga	Medicaid Asset Limits	Saga Asset Limits
1	\$ 506.22	\$ 1,600 / 1 person \$ 2,400 / 2 people \$ 4,500 car equity	\$ 1,000 / 1 person \$ 4,500 car equity
2	\$ 672.10		
3	\$ 823.68		
4	\$ 968.11		
5	\$ 1,108.25		
6	\$ 1,254.11		
7	\$ 1,415.70		
8	\$ 1,564.42		
9	\$ 1,693.12		
10	\$ 1,850.42		

***** DSS will backdate eligibility only 3 months from date of filing application*****

FEDERAL POVERTY GUIDELINES 2009

Size of Family	100% Weekly	100% Yearly	250% Weekly	250% Yearly	400% Weekly	400% Yearly
1	\$ 208.27	\$ 10,830.00	\$ 520.67	\$ 27,075.00	\$ 833.08	\$ 43,320.00
2	\$ 280.19	\$ 14,570.00	\$ 700.48	\$ 36,425.00	\$ 1,120.77	\$ 58,280.00
3	\$ 352.12	\$ 18,310.00	\$ 880.29	\$ 45,775.00	\$ 1,408.46	\$ 73,240.00
4	\$ 424.04	\$ 22,050.00	\$ 1,060.10	\$ 55,125.00	\$ 1,696.16	\$ 88,200.00
5	\$ 495.96	\$ 25,790.00	\$ 1,239.90	\$ 64,475.00	\$ 1,983.85	\$ 103,160.00
6	\$ 567.88	\$ 29,530.00	\$ 1,419.71	\$ 73,825.00	\$ 2,271.53	\$ 118,120.00
7	\$ 639.81	\$ 33,270.00	\$ 1,599.52	\$ 83,175.00	\$ 2,559.24	\$ 133,080.00
8	\$ 711.73	\$ 37,010.00	\$ 1,779.33	\$ 92,525.00	\$ 2,846.92	\$ 148,040.00

HARTFORD HOSPITAL FINANCIAL ASSISTANCE POLICY AND PROCEDURE

Effective October 29, 2008

POLICY

Guided by Hartford Healthcare charitable mission of caring for patients 24 hours a day, seven days a week, regardless of a patient's ability to pay, it is the policy of the Hospital to provide those services without charge or reduced charges to eligible patients who cannot afford to pay for that care.

GUIDELINES

These financial aid guidelines are intended to assist those low-income and uninsured individuals who do not otherwise have the ability to pay for medically necessary healthcare as prescribed by their physician and as determined by the hospital's qualification criteria.

While it is incumbent upon the hospital to have and fairly implement financial aid policies, it is incumbent upon financial aid applicants to cooperate with the hospital by providing necessary financial information and/or providing other information needed to enroll in a publicly sponsored insurance plan such as Medicaid or HUSKY. Excluded from the Financial Assistance Policy are any non covered elective procedures.

FINANCIAL ASSISTANCE

REFERRALS:

Any patient may apply for financial assistance including prior to services being rendered. Each applicant must completely fill out a Financial Assistance form. (Copy attached). Completion of the Financial Assistance application is required before granting of free bed or charity care.

EVALUATION OF APPLICATION:

1. Consider the following factors when determining the amount of Financial Assistance for which a patient is eligible at the time of application:
 - 1.1. Gross income generally should fall within federal standards for determination of poverty level with consideration to family size, geographic area, and other pertinent factors.
 - 1.2. Patients will be provided free care who have no health coverage and are within 250% of the federal poverty guidelines and liquid assets are under \$2500.00 per dependent individual.
 - 1.3. Applicants with income greater than 250% of the federal poverty guidelines will be evaluated giving consideration to the following:
 - Individual or family net worth including all liquid and non-liquid assets owned less liabilities and claims against assets.
 - Employment status along with future earnings potential.
 - Family size.
 - Other financial obligations including living expenses and other items of a reasonable and necessary nature.
 - The amount(s) and frequency of hospital and other healthcare/medication related bill(s) in relation to all of the factors outlined above.
 - 1.4. All other payment sources must be exhausted, including third-party payers, Medicaid and other government sponsored health or accident insurance or benefit programs.

- 1.5. If a patient does not have Medicaid but would qualify, he/she must cooperate with the Hospital in completing the application process. If the application is denied the patient will be considered for Financial Assistance.
- 1.6. Any questions regarding a Financial Assistance application should be referred to the Manager or Director of Patient Financial Services for guidance.
- 1.7. Foreign Nationals will be considered for Financial Assistance only for medically necessary Emergency/Urgent services after all other payment sources have been exhausted, including Medicaid.
- 1.8. Patient's that have been sponsored – must have sponsor information included. 20 % of the total gross monthly earned income from sponsor and sponsor's spouse is calculated as gross earnings. (Based on State of CT guidelines).
- 1.9. Consider any unusual social/economic circumstances and/or events that may be affecting the patient.
- 1.10. Situations such as being homeless, living at a shelter, undocumented and being supported by family members, etc.
2. Determine the appropriate amount of charity care discount in relation to the amounts due after applying all other resources. A patient who can afford to pay for a portion of the services will be expected to do so. If the patient does not pay the amount deemed to be his/her responsibility, the uncollectible remainder would become bad debt.
3. VERIFICATION of Income, Assets and Expenses on the application should be requested and provided with the application. Requirements of acceptable verification includes:
 - Prior Year Tax Returns
 - Current Pay Stubs, Written verification of wages from Employer
 - Unemployment Letter
 - Social Security Check, Disability Check
 - Sponsor's and sponsor's spouses income and assets
 - Bank Statement - Checking and saving Account information
 - Letter of eligibility for cash assistance
 - Rental Income
 - Estimated Value of Homes, Cars, Trailers. Etc.
 - Stocks, Bonds, Money Market, Trust Funds, CD's, etc.
 - Additional information such as expense/indebtedness are also required are as part of the patient determination for financial assistance.

The Financial Assistance application will be pended for two (2) weeks/ fourteen (14) calendar days for the patient to provide requested verification. If there is not a response from the patient the application will be rejected and routine hospital collection process will continue.

4. Uninsured patients who have verified their income is within 250% of the Federal Poverty Guidelines and do not have any assets (not including primary residence, a form of transportation, IRA's & 401K's) will be approved for Financial Assistance. Assets will be considered in determining qualification for Financial Assistance. The asset limit is \$1600.00 per person. For patients over the asset limit the bill will be reduced to cost. Patients will be informed that financial assistance provisions will be reevaluated on their past accounts for eligibility if the following occur:
 - Subsequent rendering of services
 - Income change
 - Asset changes
 - Family size change
 - When any part of the patient's account is written off as a bad debt or is in collections
5. Determine eligibility for financial assistance prior to and at the time of admission/registration, or as soon as possible thereafter.

6. Patient Accounts Staff, Office of Professional Services, Case Coordinators and the Social Service Department may initiate financial assistance application process. However, any hospital employee can inform patients about the Financial Assistance program and refer them to Patient Accounts.
7. Patient Accounts will notify patients in writing, regarding approval, reduced cost, denial or pending of Financial Assistance.
8. Complete applications for Financial Assistance will be reviewed and approval or denial within twenty (20) business days.
9. Patient Accounts will retain all records relating to Financial Assistance for seven (7) years.

HOSPITAL DISCOUNT POLICY:

Based on a review of annual income, uninsured patients receiving medically necessary services should be offered discounted services as described below:

- Care should be provided free for those uninsured patients who request assistance and verify their annual income is less than 250% of the Federal Income Poverty Level (FPL).
- Care should be discounted by 40% for those uninsured patients who request assistance and verify their annual income is between 250% and 400% of the FPL.

Hospitals should consider the total medical expenses faced by a family and the family's ability to pay for those expenses, an offer greater assistance when possible to those families facing catastrophic medical expenses.

Any uninsured patients above the 400% FPL will receive a 20% discount from published charges, regardless of income.

The above discount does not apply to co-pays and deductibles.

CHARITY CARE AND FREE CARE

Hartford Hospital Financial Assistance consists of Charity Care and Hospital Bed Funds (Free Bed)

Charity Care is defined as "the inability to pay" which is distinguished from Bad Debt, which is defined as the unwillingness to pay. If the patient's financial situation is such that they have not shown an ability to pay the account or express an inability to pay for various reasons, financial as well as, other is considered Charity Care.

There are allowances that go to Charity Care because of their establishment based on Charity Care criteria. Examples of these are:

- Allow Public Act 90-134
- Family Planning Clinic: Title XX
- General Policy Allowance
- Special Policy Allowance
- Scientific Interest Allowance
- Live & Donor Transp. Allowance
- General Policy Allowance
- Charity Care/Financial Hardship (Free Care)
- Charity Care (Free Care)
- Charity Care – Uninsured (Looney)
- Charity Care / Fam Pln: Title X (Free Care)
- Charity Care / Mental Hlth Cli (Free Care)

Charity Care will be used when The Hospital Bed Funds have been exhausted and/or the application does not meet the requirements of the Bed Funds available.

Free Care (Free Bed) funds represent money left to Hartford Hospital with the understanding that the income would accrue yearly to benefit financially needy patients. The Nominator is the entity/organization, which has been authorized to submit and approve Bed Fund expenditures. There are two classifications of Free Bed:

Non-Hartford Hospital Nominator Free Beds

Use of the funds have been restricted to certain entities such as Churches, Visiting Nurses Association, etc. as part of the origin.

Hartford Hospital Nominator Free Bed

Hartford Hospital Free Beds – the nominator is Hartford Hospital.

Bliss Fund – the nominator is Hartford Hospital for acceptance by Bliss Trustees Committee.

Brainard Fund – the nominator is Hartford Hospital Patient Accounts Department

APPROVAL:

There are restrictions by the donor on some of the Hospital Bed Funds. The Director of Patient Financial Services will authorize the assignment of applications to the Hospital Bed Funds following the restrictions on each fund.

Financial Applications approval is based on the individual account amounts not the total amount of the application using the following criteria:

- Financial Assistance/Patient Access Manager - \$0.00 - \$50,000.00
- Patient Accounts Director (Patient Access Director in absence of Pt Accounts Director)
\$ 50,000.01 - \$ 150,000.00
- Revenue Cycle Director > \$ 150,000.00
- Case specific to be determined by Revenue Cycle Director will go to the Executive Vice President and CFO

APPEALS:

Appeals may be made to the Director of Patient Financial Services. The Director will confer with the V.P. of Finance, V.P. of Medical Affairs, and Manager Social Service decide on the appeal.

DENTAL:

Financial Assistance funds are available for Dental emergencies, such as extraction of abscessed teeth, biopsy of lesion for cancer of mouth, face, trauma, and jaw fracture. Hartford Hospital Financial Assistance cannot be applied to Comprehensive Dental treatment, which includes the entire scope of dental treatment.

TO BE NOTED:

Applications regarding special situations will be reviewed on an individual basis and approved by the Director of Patient Financial Services.

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Patient Financial Services	Section 4: Departmental Policies	1
Approved by: Linn Weimer, PFS Director	Date Issued: 11/24/03	Last Reviewed/Revised Date: 08/20/09

Purpose: The primary responsibility of Hartford Health Care Corporation and Connecticut Children's Medical Center is to provide the highest quality of medical care to its patients at the lowest cost. In order to meet these requirements, an efficient and equitable system must be established that will maximize the collection of patient accounts receivable balances in order to provide the cash flow required to operate our institutions effectively.

Scope: All PFS Admissions, Billing and Collection areas.

Policy: In accordance with the above, the following Credit and Collection Policy is hereby established for The Hartford Health Care Corporation and Connecticut Children's Medical Center. Detailed procedures and exceptions to this policy will be included in a Credit and Collection Manual.

The Following are Procedures included in this Policy:

- I. Admissions Procedures
- II. Billing Procedures
- III. Collections Procedures

Definitions: Throughout this policy reference to Patient Financial Services will constitute reference to collection processes for Hartford Health Care Corporation and Connecticut Children's Medical Center.

In this credit policy, the term "Patient" refers to the party responsible for the payment of the hospital bill. Further, the expression, "patient portion" is to include all non-covered third party charges, such as deductibles, co-insurance, outpatient pharmacy charges, etc.

Patient classifications are defined as follows:

- A. Inpatient: Patients requiring inpatient services as deemed necessary by a physician.
- B. Emergency Patient: Patient treated in the emergency department for a condition that requires immediate attention.
- C. Private Referred: A Patient referred to one or more of the hospital's ancillary service areas by either the hospital's medical staff or other private physician.
- D. Clinic Patient: A patient who is registered in one of the hospital's outpatient areas and is treated in one or more of the specialty clinics.

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Sources of Payment	Procedure
<u>A. Patient</u>	The primary responsibility for settlement of the account will rest with the patient. All patients, capable of doing so, will be required to sign an assignment and authorization form (attached) for guarantee of payment prior to admission or receipt of services. In any controversy, default, or misrepresentation the hospital will contact the patient for payment of the bill.
<u>B. Third Party Coverage</u>	<p>Patient Financial Services will extend credit on third party benefits assigned to the hospital upon proper validation of coverage. Principal third party payers recognized in the hospital system are as follows:</p> <ul style="list-style-type: none"> • Blue Cross • Medicare/Medicaid • Managed Care Companies (contracts on file with Contract Liaison) • Commercial Insurance Companies, including medical benefits on auto insurance policies (upon assignment of benefits to the Hospital) • HMOs (upon assignment of benefits to the Hospital) • Worker Compensation (upon confirmation / validation of claim) <p>Patient Financial Services will cooperate with all third party payers to the fullest extent in order to facilitate the collection of patient bills.</p>
<u>C. Patient Balance (Self-Pay accounts and/or residual balances after third party payments)</u>	<p>Acceptable forms of payment are:</p> <ol style="list-style-type: none"> 1. Cash or money orders. 2. Personal or travelers checks with proof of identity. 3. Credit cards – MasterCard, Visa, American Express and Discover Card.

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<p>D. <u>Payment of Uninsured Hospital Charges</u></p>	<p>Patient Financial Services will require, or request payment for the difference between the estimated patient bill and the total available third party coverage. For any non-emergency services, the Hospital will attempt to obtain payment from the patient for the patient portion of the bill, after estimated coverage. All past due accounts would also be required to be paid prior to the current non-emergent admission.</p> <p>The following procedures will require payment in full prior to services being rendered.</p> <ul style="list-style-type: none"> • Pregnancy Termination • Paternity Testing • Dentures • Cosmetic Surgery • Foreign Nationals
<p>E. <u>Charity Care/ Financial Assistance</u> *Does not apply to CCMC.</p>	<p>Hartford Health Care Corporation recognizes its responsibility to those patients unable to pay for services rendered.</p> <ol style="list-style-type: none"> 1. Various Hospital Free Bed Funds are available to meet this recognized need. They are available as a last resort after all other available third party resources have been exhausted. Patients are encouraged to apply for Title XIX prior to consideration for Free Bed Funds. 2. Charity Care is also available to patients on an as needed basis. A notice of Charity Care availability is included in the Patient Statement. Patients must submit all necessary information and must meet the criteria as outline in the Financial Assistance Policy and Procedure. Exceptions may be made with the approval of PFS Director. 3. Management approval of these funds are required as follows: <ul style="list-style-type: none"> • Under \$50,000– Self Pay Manager • Up to \$150,000– P A Director • Over \$150,000 – PFS Director • Approval/denial letters are mailed to patients upon a decision is made following the review of the submitted information.

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F. Patient Inquires	Patient inquiries related to the Credit and Collection Policies of the Facilities, must be addressed by only those individuals designated within the Patient Financial Services Department.
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PROCEDURES:

I. Admissions Procedures:

Admission Type	Procedure
A. Pre-Admissions	Facilities will Pre-Admit patients whenever possible. The payment sources chosen for settlement of a patient's account will be verified prior to admission (i.e., verifying coverage thru available on-line products, confirmation directly with the payer, employer, or validation (photocopy) of appropriate insurance data). In addition, the provisions of Section III-D above must be satisfied.
B. Elective Admissions	Elective admission referrals must be received in the Pre-Admitting office, at least one day after booking the reservation in the Admitting Office or by Service Access. All elective admissions are subject to the payment of uninsured Hospital charges as established in Section III-D above.
C. Emergency Admission	Facilities will admit all emergency cases irrespective of the financial condition of the patient. The admitting physician must certify as to the <u>emergency</u> status when requesting the admission.

II. Billing Procedures:

All patient/guarantors will receive a series of statements when there is no third party coverage, or all third party coverage has been satisfied (paid or rejected).

The exceptions are:

- Medicare accounts will not receive correspondence until Medicare has paid and/or rejected the claim.

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- Medicaid accounts and accounts in which the hospital has a contractual obligation not to bill until the claim has been paid and/or rejected.
- A. Bills are produced or available for production five days after discharge. The billing process will begin as soon as the bills are available. Detail bills are available upon request.
 - B. Accounts pending coverage determination will be treated as if no coverage is available and treated as a self-pay account.
 - C. Rejected third party claims or those with a residual balance will be changed to patient pay and dunned for the amount due.
 - D. Once self-pay status is determined, financial counselors are available to assist with Title XIX applications.

III. Collection Procedures:

It is the policy of Patient Financial Services that all bills are due and payable thirty days from billing. If patient is unable to meet their financial responsibility, they will be screened in accordance with the Financial Assistance Policy.

In the event that the patient cannot obtain the necessary funding and/or use a credit card, payment arrangements would be made as a last resort under the following terms:

Monthly payments are to be established and paid each and every month. Guidelines are listed below:

BALANCE	PAYMENT PLAN
Under \$100	Payment in full
\$100 to \$350	3-month payment plan, one-third of the balance due each month
\$350 to \$1,200	6-month payment plan, one-sixth of the balance paid each month.
\$1,200 to \$5,000	12-month payment plan, one-twelfth of the balance paid each month.
\$5,000 and above	24 months

Patient statements are system generated according to the schedules outlined in sections A B and C. Accounts will be transferred to the appropriate financial class whenever payments or rejections are received from Third Party Payers.

- A. **Self Pay-Financial Class P – A/R & Daily Outpatient Accounts**
Upon discharge, final bills are processed and statements are generated based on the following cycle:

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In the event of returned mail, the statement cycle below will be interrupted and the account will be transferred to the appropriate collection agency for proper follow-up.

<u>Days after Billing (AR/Reg Date (OP))</u>	<u>Procedure</u>
10	First statement with message
35	Second statement with message
57	Third statement produced
79	Fourth Statement
101	Fifth Statement
122	<p>Reviewed for transfer to Collection Agency. Split by Hospital</p> <ul style="list-style-type: none"> • <u>Hartford Hospital</u> A-G Century Collections (FC 3) H-I Connecticut Credit (FC 1) J-R Nair & Levin (FC 5) S-Z Connecticut Credit (FC 1) • <u>MidState Medical Center</u> A – L Century (FC 3) M – Z Nair & Levin (FC 5) • <u>CCMC</u> A – L Century (FC 3) M – Z Nair & Levin (FC 5) <ul style="list-style-type: none"> ○ Daily Outpatient – automated process. ○ A/R & Unitized – manual process* <p>*(Day of transfer may vary for Unitized and may be greater than 122 days)</p>

In addition to the above schedule, telephone contact may be initiated.

B. Self Pay – Residual- Financial Class Q – A/R & Daily Outpatient Accounts

Residual balances after third party payment/rejection will proceed through the appropriate statements, messages, letters and phone calls as follows:

The day after all third parties are satisfied (paid or rejected) a statement showing the charges, credits and payments applicable thereto and the resulting self-pay balance will be produced and mailed to the patient.

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In the event of returned mail, the statement cycle below will be interrupted and the account will be transferred to the appropriate collection agency for proper follow-up.

<u>Days after FC Change</u>	<u>Procedure</u>
1	First statement with message
21	Second statement with message
42	Third statement produced
64	Fourth statement produced
86	Fifth Statement produced.
108	Sixth statement produced.
122	<p>Reviewed for transfer to Collection Agency. Split by Hospitals</p> <ul style="list-style-type: none"> • <u>Hartford Hospital</u> A-G Century Collections (FC 3) H-I Connecticut Credit (FC 1) J-R Nair & Levin (FC 5) S-Z Connecticut Credit (FC 1) • <u>MidState Medical Center</u> A – L Century (FC 3) M – Z Nair & Levin (FC 5) • <u>CCMC</u> A – L Century (FC 3) M – Z Nair & Levin (FC 5) <ul style="list-style-type: none"> ○ Daily Outpatient – automated process. ○ A/R & Unitized – manual process.* <p>*(Day of transfer may vary for Unitized and may be greater than 122 days)</p>

*System automation exists to move daily Outpatient accounts from In house Self Pay Team to the Outsourcing agency and from the Outsourcing agency to the Collection agency as follows:

1. FC P and Q accounts are worked in house for 60 days.
2. After 60 days of no resolution, the accounts are then transferred to the Outsourcing agency (currently split between Nair and CT Credit).
 - 60 days from last PT detail bill for FC P accounts.
 - 60 days from last financial class change for FC Q accounts.

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3. After 60 days with the Outsourcing agency, the account is transferred to a Collection agency (see Procedure on Section A and B.) as follows:
 - o If a payment is made and there is a balance after payment, the system will count 40 days since the last payment and then transfer the account to the Collection agency.
 - o If no payment has been made, the system will count 121 days:
 - From Registration date for FC P accounts.
 - From last Financial Class change for FC Q accounts.

C. Self Pay-Unitized Accounts:

1. Financial Class P – Account Level
Statements are produced at the on the 9th day of every month
2. Financial Class Q – Account Level
 - Statements are produced one day after financial class changed to ‘Q’ at the account level.
 - Statements are produced on the 10th day of every month after the initial financial class ‘Q’ statement.
3. Financial Class Q - Unit Level
Statements are produced on the 22nd day of every month

Accounts will advance through the self-pay cycle outlined above.

In all cases, the cycle detailed for all accounts can be interrupted by one or more of the following occurrences:

- a. Receipt and verification of third party coverage.
- b. Payment arrangements are agreed to and followed by the patient/guarantor.
- c. Evidence that the account is uncollectible or other legal consideration results in an expedited referral to an agency or attorney.
- d. Patient notifies us of inability to pay and applies for financial assistance.
- e. Follow up to complaints or appeals is required

D. Medicaid

During the Pre- Admission and/or hospitalization, Patient Accounts personnel and/or Service Access personnel will explain the Medicaid application procedure, aid the patient in completing the application and provide assistance to the patient in obtaining eligibility.

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VI. General Policies:

- A. General policies have been established to control the activities in the collection cycle.
- B. A timely filing period of 10 months from the last date of activity on the account (insurance denial/collection effort) will be followed for the billing to Patients. Once this limit is met, the patient balance will be written-off to service code 906347 "Special Purpose, Not RR". Or 906289 "special Purpose, Old RR"
- C. Patient Accounts will not Balance bill the parent of a baby born within our facilities who expire within the first 24 hours after delivery. The Insurance is to be billed. Co-Pay's and or Deductible's will be written off to Charity Care by the Self Pay Team.
- D. Patient Account Management and the Vice Presidents of Finance will review monthly write offs. The purpose of this review will be to identify the sources of bad debts and administrative write offs to propose solutions.

Author: PFS/zlb

Reviewed By: Linn Weimer, PFS Director
 Bill O'Brien, PA Interim Director
 Robert Leake, CCMC Director of Revenue and Reimbursement
 Ralph Becker, MSMC VP of Finance
 Peggy Beley, Self Pay Manager
 Lorraine Gamble, Customer Service Manager
 Hilary Dial, BSA
 Zelma Berube, Compliance

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