

NEW MILFORD HOSPITAL

TITLE: BAD DEBT WRITE OFF POLICY

It is the policy of New Milford Hospital to make every reasonable effort to collect the self pay portion of an account within 120 days from the determination of self pay liability.

It is recognized that some accounts will be deemed uncollectable, therefore, will be written off to bad debt.

No accounts will be referred to bad debt until the patient has received a Final Dunning Message on their statement except in the case of an unlocated patient with significant prior bad debt experience.

All patient balances regardless of insurance carrier, i.e. Medicaid, will be treated in the same manner for the purpose of bad debt write offs and further collection activity. (Excluding Medicaid)

All datamailers will include information advising patients of the availability of Financial Aid and the criteria to meet eligibility.

EFFORTS USED TO COLLECT PAYMENT

The hospital policy is to bill all Insurance carriers for payment. Once it has been determined that all third party reimbursement has been made a balance due statement is sent to the patient. The Patients will receive 3 reminder statements and then a final notice. Once the patient has received a final notice the account is then reviewed. The Supervisor evaluates if the account should be turned over or if additional follow up is needed. The Director then signs off on the accounts being transferred to bad debt.

BAD ADDRESS

If the hospital receives a mail return and is unable to secure current information the account will then be turned over for collection. This can be done without the patient receiving 3 statements. The hospital considers the collection agency as an extension of their collection effort. Once the accounts are turned over the collection agency follows their individual standard collection policy. The collection agency makes every effort to collect from each and every patient turned over to him or her since they work on a commission basis. (They receive payment for accounts collected, not just worked on).

REPORTS

The hospital is currently transmitting claims electronically to each agency. A paper report is generated showing the amount that was turned over. The Collection agency reports payments to the hospital monthly.

COLLECTION AGENCIES

The hospital is currently using the following collection agencies:

1. American Adjustment Bureau
2. Accelerated Collection
3. Credit Center

BANKRUPTCY

When notice is received that a patient has filed for Bankruptcy, a hold is placed on all Accts. that pertain. Bankruptcies are followed up on periodically, for approval or denial. When a "Discharge of Debtor" is received from the courts unpaid balances are written off upon approval by the appropriate Supervisor/OfficeManager/Director of the Dept.

Special Considerations:

Account balances unpaid by patients that have expired, leaving no estate or assets will be written off upon approval of the Supervisor/Manager/Director of the Dept.

Unpaid accounts held up in Probate Court, pending settlement of the estate, will be written off upon approval of the Supervisor/ Manager/Director of the Dept. The Supervisor/Manager or Director will recommend write off for cases that will continue indefinitely after claims have been filed with the appropriate party to protect the interest of the Hospital.

Accounts that remain unpaid due to Liability Claims pending settlement of litigation may be written off upon approval of the Director of Patient Accts. The Supervisor/Manager may recommend a write off of accounts in which the patient is not able to pay and the Liability Claim may continue indefinitely., only after Liens have been filed with all parties to protect the Hospital's interest.

Responsibility of the Business
Office Supervisor

1. Compile and Print B/D Transfer list. This report identifies those accounts which have progressed through the complete billing cycle and are ready to be written off to Bad Debt.
2. Review accounts on the report by checking notes entered on the system that the Self Pay collection policy has been followed regarding statements, calls, messages, etc. Edit and recycle accounts if necessary.

Director of Patient Accounts

3. Authorize B/D transfer after accounts have been reviewed and Edited by the Supervisor.

Business Office Supervisor

4. Edit and Transfer to Appropriate Agency thru Aut. B/D Transfer feature.
5. Print Bad Debt Accounts (with Detail) and DownLoad onto a disc (if applicable)/ I.D. Medicare Accts and mail to approp. Agency.
6. Reprint Bad Debt accounts from same file (No Detail) and Balance to original report.
7. After all reports done for all agencies/ cover sheet with all totals need to be tallied and signed off by Dir./Controller.

Hospital Based Assistance Programs for Uninsured Patients

Introduction to the Programs

Inpatient: Inpatient self-pay are identified by the Insurance Verification Team and by the Admitting Department. Referrals are made to the Department of Social Services for General Assistance Applications for those who qualify. The Social Service Department will refer patients to the Town Social Services for State applications. If patients do not qualify or have been denied, the Hospital has a Financial Aid Program, which works on a sliding scale. Applications can be obtained in the Customer Service Department.

Outpatient – Mammograms and Behavior Health:

Mammograms – Patients may contact Denise Mariconda at 210-5047
Behavioral Health – Assistance is based on income/sliding scale. Patients may call 350-5373 or 354-3762.

Outpatient Ancillary Services:

If there is no insurance coverage, patients may apply for Financial Aid by requesting an application from the Customer Service Department and providing necessary proof of income. Aid is based on income/sliding scale.

Self-Pay:

Patients who do not wish to apply for financial aid have two other options for help with bill payment. A specific discount may be granted if a patient chooses to pay in full during the first two billing cycles. The patient must contact the Customer Service Department to request it. A patient may also ask Customer Service for a Payment Plan at any time during the normal five-month billing period. There is a \$50 minimum monthly payment amount due, which increases based on the total original patient balance due. Any account not on a Payment Plan and not paid in full after the normal five-month billing period will be referred to an outside collection agency. Any Payment Plan account on which the patient does not comply will also be referred to an outside collection agency.

New Milford Hospital Financial Aid Basic Policy and Procedure

New Milford Hospital's Financial Aid Program is available to all persons who do not have any insurance and meet specific eligibility requirements.

1. Patients must sign and file an application with the Customer Service Department. For those applicants incapable of doing so, a family member or third party may apply for the patient on their behalf. Any non-patient applicant must include their relationship to the patient, and their signature must be notarized.
2. New Milford Hospital requires proof of income in the form of 1040 Income Tax Statements, W2 Forms, pay stubs, employer statement, copies of S. S. checks, proof of unemployment income, and any other income. If the patient/spouse has no income, the patient may supply a written statement that is witnessed and notarized. The witness is preferably a non-relation who is familiar with the applicant's financial status and mode of survival. We do not require a patient to apply for State/Town assistance although we encourage applicants to do so for other medical costs (physician bills, prescriptions and other related costs), that would not be covered under New Milford Hospital's financial aid program. If patients wish to apply for third party assistance, Financial Aid will be pended for the outcome of the third party decision.
3. Gross income and number of dependent family members determine aid levels.
 - a. Married – Gross income of applicant and their spouse.
 - b. Single-over 18 – Gross income of applicant only.
 - c. Minor-below the age of 18, living with both parents – Gross incomes of both parents.
 - d. Minor-under 18, living with one parent, financially supported by only one parent – Gross income of the parent supporting minor.
 - e. Minor-over 14 but under 17 and unmarried, who is economically separated from parents, he/she shall be considered an adult and only his/her gross income shall be considered.
 - f. Minor children and spouses are automatically included in the total family member count.
 - g. An applicant who is claiming an over age dependent must provide proof via their most recent tax return that the individual was an eligible dependent.

4. Only those patients with no insurance may qualify for financial aid. Financial Aid will be provided on a three-tier format. The reduction of 30% is equal to 251% to 400% of Poverty Guidelines, 57% reduction is equal to 201% to 250% of Poverty Guidelines and 100% reduction is equal to 200% of Poverty Guidelines. Please refer to the attached chart for current qualifying income levels.
5. Completed applications will be processed within two weeks. Pended applications will be held for no more than two months. Incomplete applications will then be denied. Only those applicants that are waiting for State/Town approval or denial will be held until a decision has been reached.
6. Applications can be pre-approved, or submitted after services have been rendered. All approved applications will be in effect for 6-months* from the authorization date.

*This time period went into effect as of 5/16/08. Previously the approved time period was 3-months.

7. If the hospital representative processing the application has knowledge of false or withheld information on an application, he/she may reserve the right to deny the application based on this knowledge.
8. Accounts already placed with a collection company that have gone legal will not be eligible for Financial Aid.

Customer Service Department Financial Aid Processing Procedure

Any patient who does not have insurance may request a financial aid application. The applications are available in the following departments: Customer Service/Cashier, Admitting, Social Services, ER, and Oncology. Applications are mailed from the Customer Service Department to patients upon request. Completed applications are to be sent to the Customer Service Department, where all financial aid applications are to be processed.

1. **Pended Applications.** If a submitted application is incomplete it is placed in the Pended Financial Aid Application file. The CSR contacts the applicant (by phone or in writing) to advise the application has been pended, and why. If the missing information is not provided, the pended application is denied after 60 days. However, the application of a patient who has applied for State Aid (Medicaid/Saga) is pended for the State's determination of patient eligibility for medical coverage.
2. **Approved Applications.** The CSR reviews an application to verify that all requested information has been supplied. When sufficient information is present, the CSR determines if the applicant is eligible for financial aid, and at what discount rate. Approved applications are then sent to the CSR supervisor for authorization. Once authorized and returned to the CSR, all applicable accounts are reviewed for eligibility*, and added to the financial aid application authorization page. An adjustment sheet** is to be completed to write off the discounted amounts being given for each account. Each account is also entered into the Financial Aid Excel spreadsheet. A copy of the authorization page is mailed to the applicant to advise the result of their financial aid application. The authorization page advises the applicant to contact the CSR Department in the event that they have further services at New Milford Hospital. However, the CSR is also responsible for a bi-monthly review of Meditech to follow up for new accounts applicable during the 6-month financial aid effective period.

*Note that for any accounts that are with a collection company, the CSR will need to contact that agency to determine if the account is eligible. Financial Aid is not available for any account under Bad Debt status that has gone legal.

*Any account on which a patient has insurance of any kind is not eligible for Financial aid.

****The Financial Aid Insurance Mnemonic is “P”, and the Adjustment Mnemonic is “AFIN.AID. However, any Bad Debt account being discounted must have the Adjustment Mnemonic of “APBADDEBT”. Each account must be listed individually as usual, and the Bill # filled out. The Description must include the level of aid being given. For example it should read “100% Fin Aid ok’d” or “57% Fin Aid”.**

3. **Denied Applications.** Applications are denied for several reasons: if the applicant has insurance, if income guidelines are not met, if the required income back-up is not supplied, or if the information supplied by the applicant is falsified. Denied applications are still signed by the CSR supervisor, and entered into the Excel spreadsheet as denied accounts. A copy of the completed authorization page, noted as denied and why, is mailed to the applicant as notification of the denial. A patient may always reapply for financial aid should their financial circumstances change, or in the event that they can produce the required proof of income information.

Enclosed:

Current Financial Aid Application

Income Guidelines

General letter to applicant regarding pending application

6/1/08, Financial Aid Procedure.doc, lms

New Milford Hospital provides financial aid to those patients who have no insurance and meet the eligibility requirements. The enclosed application must be completed if you wish to be considered for assistance under this program.

You **must** provide the following documentation in order for your application to be processed:

1. A copy of your most recent income tax return.
2. A copy of your most recent W-2 forms.
3. A copy of your most recent pay stub showing year-to-date earnings.
4. Proof of any disability and/or unemployment income.

In the event that you cannot provide all of the above items, we request that you provide a **notarized** letter explaining your financial situation. The letter should explain why you do not have the above documentation; explain your income situation, and indicate how you are surviving. Please indicate how you are paying your bills; if someone is supporting you.

Once your application has been processed, you will be notified by mail regarding the outcome. You will receive a copy of the last page of this application, showing the level of discount that has been authorized. If we receive an incomplete application from you, it will be pended for no more than 60 days. We will advise you by phone or mail regarding the missing information. If you do not supply that information within the 60 days, then your application will be denied as incomplete.

If you have any questions regarding this application procedure, please feel free to contact our Customer Service Department at 800-695-6639, or locally at (860)210-7420, between 8:00-4:00, Monday through Friday.

PATIENT'S NAME: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY STATE ZIP

SOCIAL SECURITY# HOME PHONE DOB EMPLOYER

OF MEMBERS IN HOUSEHOLD (Immediate family only): _____
LIST THEIR NAMES, DATES OF BIRTH, AND RELATION TO THE PATIENT:

GROSS FAMILY INCOME LAST YEAR: \$ _____, LAST 3 MONTHS: \$ _____

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicare, Medicaid, etc.) which may be available to me for payment of my hospital bill, and will assign or pay benefits to the hospital the amount recovered for the hospital charges.

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

DO YOU HAVE INSURANCE? _____ YES _____ NO
IF YES, NAME OF THE INSURANCE COMPANY: _____

APPLICANT'S SIGNATURE: _____ DATE: _____

ELIGIBILITY DETERMINATION (HOSPITAL USE ONLY)

DATE APPLICATION RECEIVED: _____ COMPLETED OR PENDING

INCOME VERIFICATION BASED ON: _____

_____ APPLICANT IS ELIGIBLE FOR FINANCIAL AID. AMOUNT OF AID: _____ %

_____ REQUEST FOR AID IS DENIED. REASON: _____

DATE OF DETERMINATION: _____ CSR SIGNATURE: _____

HOSPITAL DETERMINATION OF AID AND AUTHORIZATION

YOUR APPLICATION FOR FINANCIAL AID HAS BEEN REVIEWED BY NEW MILFORD HOSPITAL. WE FIND YOUR APPLICATION DOES/ DOES NOT MEET THE REQUIREMENTS FOR FINANCIAL AID FOR THE FOLLOWING ACCOUNTS:

<u>NAME</u>	<u>DATE OF SRVC.</u>	<u>ACCT #</u>	<u>BALANCE</u>	<u>AID AMNT</u>	<u>PATIENT BALANCE</u>
_____	_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____	_____

AUTHORIZED SIGNATURE: _____ DATE: _____
REMARKS (optional): _____

NOTE TO PATIENT:
THIS APPLICATION WAS APPROVED ON THE DATE ABOVE AND IS VALID FOR THE DATES OF SERVICE LISTED. IN ADDITION, THE LEVEL OF AID GRANTED WILL CONTINUE TO BE IN AFFECT FOR AN ADDITIONAL 6 MONTHS FROM THE DATE OF AUTHORIZATION. IN THE EVENT THAT YOU HAVE ELIGIBLE SERVICES AT NEW MILFORD HOSPITAL THROUGH _____, PLEASE CONTACT OUR CUSTOMER SERVICE DEPARTEMENT SO THAT WE CAN ADD THE NEW ACCOUNT(S) TO THIS APPLICATION FOR AID.

FINANCIAL AID FEB 2009

FAMILY SIZE	INCOME FOR 100% FREE CARE			INCOME FOR 57% REDUCTION			INCOME FOR 30% REDUCTION		
	UP TO 200% OF Poverty Guidelines			200.01 TO 250% OF Poverty Guidelines			250.01 TO 400 % OF Poverty Guidelines		
1	\$0	TO	\$21,660	\$21,661	TO	\$27,075	\$27,076	TO	\$43,320
2	\$0	TO	\$29,140	\$29,141	TO	\$36,425	\$36,426	TO	\$58,280
3	\$0	TO	\$36,620	\$36,621	TO	\$45,775	\$45,776	TO	\$73,240
4	\$0	TO	\$44,100	\$44,101	TO	\$55,125	\$55,126	TO	\$88,200
5	\$0	TO	\$51,580	\$51,581	TO	\$64,475	\$64,476	TO	\$103,160
6	\$0	TO	\$59,060	\$59,061	TO	\$73,825	\$73,826	TO	\$118,120
7	\$0	TO	\$66,540	\$66,541	TO	\$83,175	\$83,176	TO	\$133,080
8	\$0	TO	\$74,020	\$74,021	TO	\$92,525	\$92,526	TO	\$148,040

For EXPRESS BILL STATEMENTS

Size of Family	Annual Income (must be under)
1	\$43,320
2	\$58,280
3	\$73,240
4	\$88,200
5	\$103,160
6	\$118,120
7	\$133,080
8	\$148,040

Poverty Guidelines

Size of Family	Poverty Guidelines
1	\$10,830
2	\$14,570
3	\$18,310
4	\$22,050
5	\$25,790
6	\$29,530
7	\$33,270
8	\$37,010