

## DOCUMENT INFORMATION:

Subject: Financial Assistance Policy

## PURPOSE:

- A. Danbury Hospital is committed to advancing the health and well-being of those in its community by providing an integrated high quality and cost effective network of health care services and education centered around a teaching hospital, consistent with current medical standards for the prevention, diagnosis, treatment, and rehabilitation of illness; and anticipating and responding to new developments in the health care system; and integrating its services with those of other medical and social service organizations in the region (e.g., home health care agencies, long term care facilities, and physical, mental, alcohol, and drug rehabilitation) so as to optimize the availability of such services within the region in a cost effective manner. Consistent with this mission, Danbury Hospital recognizes its obligation to the community it serves to provide financial assistance to indigent persons within the community.
- B. In furtherance of its charitable mission, Danbury Hospital will provide both (i) emergency treatment to any person requiring such care; and (ii) essential, *non-emergent* care to patients who are permanent residents of its primary service area who meet the conditions and criteria set forth in this Policy, without regard to the patients' ability to pay for such care. Elective procedures generally will not be considered essential, non-emergent care and usually will not be eligible for Financial Assistance.

## POLICY:

- C. Danbury Hospital is a not for profit, tax-exempt entity with a charitable mission of providing medically necessary health care services to residents of the City of Danbury and the Hospital's defined primary service area, regardless of their financial status and ability to pay.
- D. It is the policy of Danbury Hospital to provide "Financial Assistance" (either free care or reduced patient obligations) to persons or families where: (i) there is limited or no health insurance available; (ii) the patient fails to qualify for governmental assistance (for example Medicare or Medicaid); (iii) the patient cooperates with the Hospital in providing the requested information; (iv) the patient demonstrates financial need; and (v) Danbury Hospital makes an administrative determination that Financial Assistance is appropriate.

- E. After the Hospital determines that a patient is eligible for Financial Assistance, the Hospital will determine the amount of Financial Assistance available to the patient by utilizing the Charitable Assistance Guidelines (**Exhibit 1**), which are based upon the most recent Federal Poverty Guidelines issued by the U.S. Department of Health and Human Services (“FPGs”).
- F. In the case of patients who qualify for discounted (but not free) care, the Hospital will work in good faith with patients to establish payment plans that are fair and workable in light of each patient’s available resources.
- G. Danbury Hospital will regularly review this Financial Assistance Policy to ensure that at all times it: (i) reflects the philosophy and mission of the Hospital; (ii) explains the decision processes of who may be eligible for Financial Assistance and in what amounts; and (iii) complies with all applicable state and federal laws, rules, and regulations concerning the provision of financial assistance to indigent patients. In the event that applicable laws, rules or regulations are changed, supplemented or clarified through interpretative guidance, the Hospital will modify this Policy and its practices accordingly.

## PROCEDURE:

### II. ELIGIBILITY AND DETERMINATION OF AMOUNT

- A. Eligibility: A patient will be eligible for Financial Assistance if the patient: (i) has limited or no health insurance; (ii) applies for but is deemed ineligible for governmental assistance (for example Medicare, Medicaid or State-Administered General Assistance); (iii) cooperates with the Hospital in providing the requested information; and (iv) demonstrates “financial need” or is deceased with no estate, no payment source and no health insurance. In addition, a patient will be eligible for Financial Assistance in the event Danbury Hospital administration, in its discretion, deems such eligibility appropriate under a patient’s unique circumstances (for example, where a patient has insurance coverage but lacks the financial resources to pay applicable co-pays, deductibles and excess amounts). For purposes of this Policy, the term “patient” is used with regard to the patient or the applicable payment source for the patient’s care (e.g., parent, guardian or other responsible party).
- B. Financial Need: A patient may be deemed to have financial need: based on either **indigency/financial hardship** or **medical hardship** (each as defined below).

Indigency/Financial Hardship: A patient may demonstrate financial hardship by showing that the patient has **income** and **available assets** below the FPG thresholds set forth on **Exhibit 1** (as amended from time to time to reflect the most current FPGs published by DHHS). For these purposes, “income” includes salaries, legal judgments, unemployment compensation, dividends, interest checks and other recurrent sources of income or resources. “Available assets” includes savings, certificates of deposit, individual retirement accounts, marketable securities or similar

liquid assets readily convertible to cash (however, in no event will this term include a patient's primary residence).

If a patient's income and available assets combined are at or below **600%** of the FPGs, the patient will receive some form of Financial Assistance. The Financial Assistance may be either a complete waiver of all patient responsibility or a discount or reduced patient obligation, depending on the patient's income.

- If a patient's income and available assets combined fall between **0%** and **400%** of the FPGs, the patient will have no financial responsibility for the care provided by the Hospital. This means that the full charges for services rendered (including copayment and deductible amounts) are completely waived.
- If a patient's income and available assets combined are greater than **400%** of the FPGs but not more than **500%** of the FPGs, the patient will qualify for a 50% discount on the charges for services rendered.
- If a patient's income and available assets combined are greater than **500%** of the FPGs but not more than **600%** of the FPGs, the patient will qualify for a 30% discount on the charges for services rendered.

2. Medical Hardship: In addition to income and assets, Danbury Hospital will also consider Financial Assistance where a patient's medical bills are of such an amount that payment threatens the patient's financial survival. In such circumstances, the discount to be offered to the patient will be determined by Hospital personnel in their discretion.

C. Calculation of Amounts to Be Billed: The net amount to be billed to a patient qualifying for financial assistance hereunder will be determined by (i) calculating the gross charges for services rendered to the patient, and (ii) applying the appropriate discount (as determined pursuant to the above and Exhibit 1). Notwithstanding the foregoing, however:

1. Consistent with Connecticut law, any uninsured patient whose income (alone, without regard to available assets) falls below **250%** of the FPGs will not be charged more than Danbury Hospital's cost of providing services to the patient; and
2. Consistent with applicable Federal tax laws, the net amount billed to any patient qualifying for financial assistance pursuant to this Policy (after applying the appropriate financial assistance discount determined above) will not exceed the greater of (i) the net amount that would be charged based on applying an average of the Hospital's three highest commercial payor discounts, or (ii) Medicare rates.

### III. PROCEDURES AND OBLIGATIONS FOR DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE

- A. All self-pay patients will be informed of the availability of financial assistance pursuant to this Policy.
- B. Because a patient is not eligible under this Policy until s/he has applied for and been deemed ineligible for federal and state governmental assistance programs, Danbury Hospital's Financial Services Department will assist patients in enrolling in federal and state governmental assistance programs. Trained financial counselors and other personnel may be contacted at (203) 739-7773 or (203) 730-5800 for any assistance required in completing the Application for Financial Assistance or with any other materials required by the Hospital under this Policy.
- C. Although ideally the Hospital will make a determination about Financial Assistance during pre-registration or prior to discharge, this may not be possible, either because the patient does not provide the necessary documentation, or the patient's circumstances change after discharge, or in other circumstances where a given patient's circumstances or needs are identified. **A patient may request consideration at any time, and Danbury Hospital will evaluate a patient's eligibility under this Policy as requested, up to and including consideration during the collections and judgment phase.** Patients are encouraged to contact the Hospital if their circumstances change or if additional need is identified. The Hospital will review all information provided and relevant circumstances bearing on the need for Financial Assistance, will make a determination of eligibility, and will promptly notify the patient of his/her financial obligations, if any, as set forth below.
- D. Eligibility Determination Procedure
  - 1. Hospital staff will immediately forward to the Hospital's financial counselors a copy of the pre-admission record for any patient who has no insurance. Financial counselors will contact the patient to schedule a financial interview as soon as is practicable but ideally before admission for a non-emergent, medically necessary service, and prior to discharge for an emergency admission. For emergency services, the Hospital will not delay screening or treatment of an emergency medical condition pending this financial interview.
  - 2. To determine whether a patient is eligible for Financial Assistance, the patient will be required to complete the Patient Financial Worksheet (**Exhibit 2**). The Worksheet will be made readily available to patients through methods including (without limitation) posting on the Hospital's website, distribution at the Hospital's Patient Registration and Admissions areas and the Patient Financial Services offices, and inclusion in the informational binders provided in patient rooms.
  - 3. Patients must return the Worksheet to the financial counselor in the self-addressed stamped envelope provided by the Hospital within ten (10) days. Failure to timely supply required information will result in denial of

a patient's request for provision of Financial Assistance. Patients are obligated to cooperate and provide all information needed in a timely manner. The Hospital will make reasonable efforts to offer and provide assistance to patients in connection with the completion of the Worksheet. However, if assistance is needed in gathering necessary information or materials requested as part of the Financial Assistance qualifying process, patients are encouraged to contact one of the Hospital's trained financial counselors at (203) 739-7773 or (203) 730-5800. Financial counselors also are available to assist patients with assessing their financial situations, gathering information requested by the Hospital, and assisting with similar tasks.

4. As part of the financial interview process, financial counselors will request the following documentation in order to process and validate Financial Assistance applications:
    - a. Confirmation of annual income and assets:
      - Last four pay stubs and/or W2 form, social security award, unemployment compensation letter
      - Most recent income tax return
      - Most recent checking and savings account statements for all accounts upon which patient is listed as an account-holder
      - Banking/investment account statements
    - b. Confirmation of patient's Social Security Number and birth date. Proof must be in the form of one of the following:
      - Social Security Card
      - Birth certificate
      - Baptismal Certificate
      - Military Discharge Papers
      - School Records
      - Drivers License
    - c. Confirmation of residence in the form of one or more of the following:
      - Mortgage Book
      - Current Rent Receipt
      - Current Lease
      - Tax Bill
      - Room and Board Statement
      - Utility Bill
      - Written Verification from Landlord
- E. Although the information above is required from patients seeking Financial Assistance, the Hospital in its discretion may choose not to require some or all

documentation depending upon circumstances and the patient's ability to obtain documentation.

- F. Patients have an obligation to provide information reasonably requested by the Hospital so that the Hospital can make a determination of a patient's eligibility for Financial Assistance. **If a patient claims s/he has no means to pay but fails to provide the information reasonably requested by the Hospital, there will be no Financial Assistance extended and normal collection efforts may be pursued in the Hospital's sole discretion.**
- G. Eligibility and Notification Process:
1. Upon receipt of a patient's Patient Financial Worksheet, the Financial Services Department will review the patient's application to determine that it is complete, including all required documentation. If it is not complete, the application will be returned to the patient for completion. If the Hospital returns an application to a patient as incomplete, the Hospital will contact that patient by telephone. If the Hospital is able to reach the patient by telephone, the Hospital will offer the patient an in-person or telephonic interview to determine such patient's eligibility for Financial Assistance. If the Hospital is unable to reach the patient by telephone, or if there is no listed telephone number available, the Hospital will send a letter to the patient that details what is needed and that explains to the patient that it is his/her responsibility to contact the Hospital within ten (10) days of receiving the letter. The Hospital's trained financial counselors will offer to meet with the patient to assist him/her in completing the application so that the Hospital has all of the necessary information to make a determination on the patient's eligibility for Financial Assistance.
  2. The Financial Services Department will complete the Financial Assistance Eligibility Determination Form attached as **Exhibit 3**, and will determine the amount the patient owes, if any. The Financial Services Department will inform the patient of his/her eligibility for Financial Assistance, and the amount of such Financial Assistance, within five (5) business days of the determination.
  3. A determination of eligibility under this Policy will be effective for one (1) year. At the end of such time period, patients continuing to require essential medical services will be expected to re-apply or update their prior applications, in order to permit the Hospital to make a new determination regarding the patient's continuing eligibility for Financial Assistance.

#### **IV. COMMUNICATION**

The Hospital will communicate the availability of Financial Assistance to its patients and the general public through measures that include providing or posting copies of this Policy, summaries thereof (if more conducive to patient understanding), appropriate signage and/or brochures:

- On the Hospital's website;
- In the Hospital's Emergency Department;
- In the Patient Registration and Admissions areas;
- In the Patient Financial Services Department;
- In other waiting areas throughout the Hospital premises (as may be reasonably workable and appropriate);
- In patient informational binders included in patient rooms; and
- In bills and statements sent to patients.

As provided above, Patient Registration staff and Patient Financial Counselors will ensure that all self-pay patients are notified regarding the availability of Financial Assistance per the terms of this Policy.

Pertinent materials will be provided in English, Portuguese, and Spanish, which are the languages appropriate to the community served by the Hospital. All such materials will include pertinent contact telephone numbers and/or e-mail addresses to permit patients appropriate resources for completion of the Worksheet and answers to any other questions they may have about the Hospital's Financial Assistance Program.

## **V. DOCUMENTATION AND RECORDKEEPING**

- A.** The Financial Services Department will maintain all documentation of Financial Assistance within the Hospital's Financial Assistance file. The Financial Assistance file will include a cumulative total of Financial Assistance cases, together with supportive documentation. Supportive documentation will include, at a minimum, the following:
- The number of applicants for free and reduced cost services;
  - The number of approved applicants;
  - The total and average charges and costs of the amount of free and reduced cost care provided;
  - Any other information required by, or necessarily to permit complete and accurate reporting under, applicable federal and state laws (including without limitation CT Public Act 03-266).
- B.** The Vice President of the Revenue Cycle will review the status of the Financial Assistance program with the Chief Executive Officer, or his/her designee, on a regular basis. The Chief Executive Officer or his/her designee will be responsible for presenting this Financial Assistance Policy to the Board of Directors at least annually. Such presentation will include a detailed statement on what the Hospital's policy is on Financial Assistance, the impact of this Financial Assistance Policy on Hospital operations and the level of need and benefits being conferred to the community under the Hospital's Financial Assistance program.
- C.** Information about the amount of Financial Assistance provided will be provided in accordance with federal and state laws and regulations on reporting information under the Hospital's Financial Assistance Policy.

## **VI. PATIENT RIGHTS AND RESPONSIBILITIES**

- A.** To be eligible for Financial Assistance, the patient must cooperate with the Hospital by providing the necessary information and documentation necessary to apply for appropriate federal and state governmental assistance and other financial resources that may be available to pay for his/her health care. Prior to being considered eligible for Financial Assistance from Danbury Hospital, the patient must apply for all other appropriate sources of financial assistance. Danbury Hospital will assist patients with making such applications by providing assistance in completing the relevant forms and by assisting the patient with understanding how his/her income and assets relate to the Hospital's Charitable Assistance Guidelines. Consistent with this Policy, where the Hospital is aware that a patient will not qualify for a particular type of federal or state governmental assistance (e.g., based upon citizenship), the Hospital may waive the requirement that the patient apply for such assistance prior to becoming eligible for Financial Assistance.

- B.** Any request for Financial Assistance will be made by or on behalf of a patient. Patients may apply for, and will be encouraged to apply for, Financial Assistance before, during or within a reasonable time after Hospital care is provided. In the event a patient does not initially qualify for any Financial Assistance, the patient may re-apply upon a showing of change in circumstances.
- C.** Patients who are deemed eligible for any Financial Assistance must: (i) cooperate with the Hospital to establish a reasonable payment plan, which will take into account all available income and assets, the amount of the discounted bill and any prior payments; and (ii) make good faith efforts to honor any agreed-to payment plan for their discounted Hospital bills. Patients who fail to make payments according to their established payment plans will be contacted by the Hospital by telephone and in writing to address the circumstances; in such cases, Hospital Financial Counselors will work with patients to establish a modified payment plan suitable to the patient's needs and resources. However, if a patient refuses contact from the Hospital or otherwise fails to respond after repeated efforts by the Hospital over a reasonable time period, the Hospital may submit a patient's account to collection. In that context, collection measures may include garnishment, liens (including on residences) and other practices consistent with applicable law.
- D.** Patients are responsible for communicating to the Hospital any change in financial status that may adversely impact their ability to pay their discounted Hospital bill or to honor the provisions of their payment plans. Similarly, in the event that a patient's financial circumstances become more favorable while receiving assistance under the Hospital's Financial Assistance program, the patient will be required to notify the Hospital of such change in circumstances.

## FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES

Based on 2013 Federal Poverty Guidelines

<u>Family Size</u>	<u>Federal Poverty Guidelines (2013)</u>	<u>250% - 400 % (or Below) Poverty Guidelines (100% write-off)</u>	<u>400% - 500% Poverty Guidelines (50% write-off)</u>	<u>500% to 600% Poverty Guidelines (30% write-off)</u>
<u>1</u>	<u>\$11,490</u>	<u>\$28,725 to \$45,960</u>	<u>\$45,961 to \$57,450</u>	<u>\$57,451 to \$68,940</u>
<u>2</u>	<u>\$15,510</u>	<u>\$38,775 to \$62,040</u>	<u>\$62,041 to \$77,550</u>	<u>\$77,551 to \$93,060</u>
<u>3</u>	<u>\$19,530</u>	<u>\$48,825 to \$78,120</u>	<u>\$78,121 to \$97,650</u>	<u>\$97,651 to \$117,180</u>
<u>4</u>	<u>\$23,550</u>	<u>\$58,875 to \$94,200</u>	<u>\$94,201 to \$117,750</u>	<u>\$117,751 to \$141,300</u>
<u>5</u>	<u>\$27,570</u>	<u>\$68,925 to \$110,280</u>	<u>\$110,281 to \$137,850</u>	<u>\$137,851 to \$165,420</u>
<u>6</u>	<u>\$31,590</u>	<u>\$78,975 to \$126,360</u>	<u>\$126,361 to \$157,950</u>	<u>\$157,951 to \$189,540</u>
<u>7</u>	<u>\$35,610</u>	<u>\$89,025 to \$142,440</u>	<u>\$142,441 to \$178,050</u>	<u>\$178,051 to \$213,660</u>

**\*\* For family units with more than 8 members, add \$4,020.00 for each additional member.**

**Note: This Exhibit shall be updated from time to time to reflect the most current FPGs issued by the U.S. Department of Health and Human Services.**

**PATIENT/PAYMENT SOURCE FINANCIAL WORKSHEET**

**Patient Name:** \_\_\_\_\_

**Account Number:** \_\_\_\_\_

**Household Size:** \_\_\_\_\_

**1A Calculation of Available Income**

Monthly Salary/Pension	_____	x 12	_____
Monthly SSI/VA	_____	x 12	_____
Income Total	_____	x 12	_____ (AA)

**1B Calculation of Monthly Expenses**

Rent	_____
Electric	_____
Gas	_____
Telephone	_____
Water	_____
Car Payments	_____
Credit Cards	_____
Insurance	_____
Other _____	_____
Food (\$100.00 x dependents)	_____
Monthly Expense Total	_____
Expense Total	_____ x
12 _____ (BB)	

**1C Eligible Income for Hospital Bills** \_\_\_\_\_ (CC)  
(AA – BB) (if less than 0, enter 1)

**1D Estimate Hospital Billing to Patient** \_\_\_\_\_ (DD)

**1E Identification of Liquid Assets**

Bank Accounts	_____
Bonds	_____

Stocks \_\_\_\_\_  
CD's \_\_\_\_\_  
Mutual Funds \_\_\_\_\_  
Liquid Asset Total \_\_\_\_\_(EE)

1F Total Patient Due Minus Liquid Assets (DD- EE) \_\_\_\_\_(FF)

1G Eligible Income Minus Patient Due (CC-FF) \_\_\_\_\_(GG)

Note: If GG is a negative number, then patient will have no financial responsibility.

\_\_\_\_\_ I attest that the above information is correct.

\_\_\_\_\_ I attest that the Patient/Payment Source is unemployed and cannot provide employment documentation.

\_\_\_\_\_  
SIGNATURE OF PATIENT/PAYMENT SOURCE

\_\_\_\_\_  
DATE

**FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION FORM**

Date: \_\_\_\_\_

Danbury Hospital has conducted an eligibility determination for Financial Assistance for:  
Name: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

The completed request for Financial Assistance was submitted by the patient or on behalf of the patient on: \_\_\_\_\_

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made.

\_\_\_\_\_ Your request for Financial Assistance has been denied because your income and available assets exceed those set forth in Danbury Hospital's Financial Assistance Guidelines.

\_\_\_\_\_ Your request for Financial Assistance has been approved for services rendered on \_\_\_\_\_. The entire balance will be treated as free care.

\_\_\_\_\_ Your request for Financial Assistance has been approved in accordance with the criteria under P.A. 03-266 for services rendered on \_\_\_\_\_.

\_\_\_\_\_ You qualify for a discount on charges consistent with the Hospital's sliding scale. This office will contact you to establish a payment plan.

\_\_\_\_\_ Your request has been denied for the following reason:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Other (please described in detail):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have questions about this determination, please contact:

\_\_\_\_\_ at (203) \_\_\_\_\_, extension \_\_\_\_\_.

**Originator (Department): Revenue Cycle**

**Original Date: 10/01/12**

**Revision Date: 05/20/13**

**Review Date: 05/20/13**

**Regulatory Agency/Agencies & Ref Number(s):**

**Replaced Policy & Procedure (if applicable):**

**Committee Approvals & Dates:**

**Department Head Approval: Mary Brannigan Lowe**

**Administrative Approval & Date: 05/20/13**

**EXECUTIVE LEADER**

These policies and procedures are for the use of Western Connecticut Health Network (WCHN) and are not to be disseminated to any other organization without the prior written approval from the above signed Administrator.