LADMC LA DOWNTOWN MEDICAL CENTER LLC	
DEPARTMENT: BUSINESS OFFICE – NON GOVT ☐ Ingleside Campus ☐ Downtown Campus	POLICY TITLE: **COLLECTION AGENCY UTILIZATION**
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APPROVED BY:	APPROVAL/EFFECTIVE DATE: 03/18/2019
EFFECTIVE DATE/REVISED DATE(S): 03/18/2019, 03/18/2022	
NEXT REVIEW DATE: **03/18/2025**	☐ RETIRED DATE:
ATTACHMENTS:	

PURPOSE

To standardize policies concerning the use of collection agencies. To insure the proper handling of accounts submitted to collection agencies.

RELATED POLICIES

1. Bad Debt Write Off

POLICIES

1. The Corporate Office must approve selection of collection agencies.
2. Accounts deemed uncollectible shall be placed with agencies in a timely manner.
3. Collection agencies shall reconcile monthly all payments received with all payments reported by the facility and either invoice for commissions earned or remit check to facility for amounts due.
4. Collection agencies shall report their entire inventory, including the current status of each account, on a monthly basis.
5. Collection agencies shall never remove original patient financial folders from the facility for any reason.

PROCEDURES

1. Monthly reporting formats shall include the entire inventory of accounts placed with the collection agency. Additionally, the following reports shall be provided:
    a. A master list including the following items:

1. Patient name
2. Hospital account number
3. Date of service
4. Date of placement
5. Amount assigned
6. Current client balance
7. Current month's payment
8. Payment date
9. Total paid since assignment

b. An inventory performance analysis report shall include a minimum of specified items:

1. Financial status, categorized by patient type, reflecting the number and dollar amount of accounts:

   a. Paid in full
   b. Currently paying
   c. Legal Accounts
   d. Legal inactive accounts
   e. Cancel/Returns by facility
   f. Cancel/Returns by agency

c. A cancellation analysis report shall contain a minimum of specified items:

1. Financial status, categorized by patient type, reflecting the number and dollar amount of accounts:

   a. Cancelled by facility
   b. Bankrupt
   c. Deceased
   d. Medicaid
   e. Uncollectible

d. A monthly analysis of year to date activity with specified items:

1. Categorized by month reflecting the number and dollar amount of accounts:

    a. Accounts assigned
    b. Accounts canceled/returned
    c. Collections
    d. Active accounts
    e. Recovery percentage

e. Monthly payment analysis report containing a minimum of specified items:

1. Categorized by patient type with the number and dollar amounts of accounts:

    a. Paid in full
    b. Current payments
    c. Remaining balance

3. Collection commissions will be paid through the accounts payable system monthly net of cash collected directly by the agency.

a. The agency must bill for commissions under a separate invoice on a monthly basis:

1. The Business Office Manager shall review and approve the commission invoice and present to Chief Financial Officer with a completed check request form for approval.

4. Reporting of payments received at the facility for accounts placed with agencies:

a. Payments may be accepted at the facility for accounts placed with collection agencies. Payments by check that indicate "Payment in full" on the check shall not be accepted unless the amount due has been verified with the agency and documented.

1. A copy of each payment received shall be sent to the collection agency in a timely manner for updating and reconciling account balances.

2. The payment shall be posted into the hospital's system using the date of actual deposit. To return the account balance to zero, a second transaction shall be made to reverse the amount of the payment from the initial "collection agency adjustment" applied.

5. Upon assignment the Business Office shall provide agency with billing copy, face sheet, insurance information, payment history, correspondances, signed assignment of benefits, conditions of admission statement, and A/R notations reflecting collection activities..

LADMC LA DOWNTOWN MEDICAL CENTER LLC

CHARITY CARE APPLICATION
Request for Uncompensated Services

Account# _____ Date of Service: _____

Name: _____
First Middle Last

Address: _____
Number/Street City State Zip

Telephone ( ) _____

Sex Code _____ 1-Male 2-Female

Date of Birth: / /

Ethnicity: Enter ethnicity code as follows: _____
(1) White (4) Native American/Eskimo
(2) Black (5) Asian/Pacific Islander
(3) Hispanic (6) Other _____

Family Size: _____

Name Age Sex

_____

_____

_____

_____

Family Principal Income Source:

Code: _____

(01) Professional/Technical Employment
(02) Labor/Production Employment
(03) Agricultural Employment
(04) Service/Sales Employment
(05) Unemployment Compensation
(06) Retirement Income
(07) Disability Income
(08) General Relief
(09) Other Income Source
(10) None

Potential 3rd Party Payor Source:

Code: _____

(1) Private Insurance
(2) Medi-Cal
(3) Medicare
(4) Self Pay
(5) Other
(6) None

INCOME: List income for family from:	MONTHLY	ANNUAL
Wages (Self)		
(Spouse)		
(Other Family Members)		
Farm or self-employed		
Public Assistance		
Social Security		
Unemployment Compensation		
Worker's Compensation		
Strike Benefits		
Alimony		
Child Support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest, Rent		

TYPE OF SERVICE: Code: _____

(1) Hospital Inpatient
(2) Hospital Outpatient
(3) Hospital Emergency Room

UNITS OF SERVICE:

I/P Days _____
O/P Visits _____
E/P Visits _____

Billed Amount $ _____

Repayment Collected $ _____

Other Write-Offs $ _____

Patient Liability $ _____

Date of Service: _____

Expenses (Monthly)

Mortgage/Rent	$
Medical Insurance	$
Utilities	$
Auto Insurance	$
Telephone	$
Medical Bills	$
Food	$
Hospital	$
Finance Companies	$
Physicians	$
Credit Union	$
Medications	$
Auto Loans	$
Total Expenses:	$

Net Worth

Do you own your home? ( ) Yes ( ) No

If yes, estimate value: _____
Less outstanding owed: _____
Net Value: _____

Do you own other property? ( ) Yes ( ) No

If yes, estimate value: _____
Less outstanding owed: _____
Net Value: _____

Do you own automobile? ( ) Yes ( ) No

Amount _____ Net _____

Model/Make Year	Value Owed	Value

BANK REFERENCES:

Name/Branch: _____ Account# _____

Name/Branch: _____ Account# _____

Total Net value of all items in this section: _____

Liability Computation

Plus Total Monthly Gross Income	(A)	Adjusted Net Monthly
Minus Monthly Deductions	(B)	
Income	(A-B)	

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge

I agree totell the provider of service within ten (10) days of there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses or in the persons in the household or any change of address.

I understand the county is required by law to keep any information I provide confidential.

I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county from the proceeds of any litigation or settlement resulting from such act.

Signature _____ Date _____

For Hospital Use Only: _____ Accepted _____ Denied

Comments: _____

Signature _____ Date _____