SSTAR Family HealthCare Center
2016 HSN Credit and Collection Policy

1. GENERAL FILING REQUIREMENT

613.08(1)(C) Electronic Filing with Table of Contents
The SSTAR Family HealthCare Center will electronically file a Credit and Collection Policy that is reflective of its practices with the Health Safety Net Office in each of the following circumstances:

a. a new Provider must file a copy of its Credit and Collection Policy prior to Health Safety Net Office approval to submit claims for payments;
b. within 90 days of adoption of amendments to 101 CMR 613.00 that would require a change in the Credit and Collection Policy;
c. when a Provider changes its Credit and Collection Policy; or
d. when two Providers merge and request to be paid as a single merged entity.

2. GENERAL DEFINITIONS OF EMERGENCY CARE & URGENT CARE

613.02 Emergency Care definition to be used in determining Allowable Bad Debt under 613.06
N/A

613.02 Urgent Care definition to be used in determining Allowable Bad Debt under 613.06
Urgent Care. Medically Necessary Services provided in an Acute Hospital or Community Health Center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in placing a Patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent Care Services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health. Urgent Care Services do not include Primary or Elective Care.

3. GENERAL COLLECTION POLICIES & PROCEDURES

613.08(1)(C)2a Standard collection policies and procedures for patients
(a) The health center makes reasonable efforts prior to or during treatment to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor. The center's staff provides all first-time patients with a registration form which includes questions on the patient's insurance status, residency status, and financial status, and provides assistance, as needed, to the patient in completing the form. A patient who states that they are insured will be requested to provide evidence of insurance sufficient to enable the center to bill the insurer. Health center staff ask returning patients, at the time of visit, whether there have been any changes in their insurance coverage status. If there has been a change, the new information is recorded in the center's practice management system and the patient advised or assisted to inform MassHealth of the change.

(b) The health center undertakes the following reasonable collection efforts for patients who have not provided complete eligibility documentation, or for whom insurance payment may be available:

(1) an initial bill is sent to the party responsible for the patient's financial obligations;
(2) subsequent billings, telephone calls, and any subsequent notification method that constitute a genuine effort to contact the party which is consonant with patient confidentiality are sent;
(3) efforts to locate the patient or the correct address on mail returned as an incorrect address are documented, and
(4) a final notice is sent by certified mail for balances over $1000, where notices have not been returned as an incorrect address or as undeliverable.

(c) Cost Sharing Requirements. Health center staff inform patients who are responsible for paying co-payments and deductibles, that they will be responsible for these co-payments.

(d) Health Safety Net - Partial Deductibles/Sliding Fees: For Low Income Partial patients, the health center determines their deductible. The patient is responsible for 20% of the HSN payment for each visit, and this will be applied to the patient's annual deductible. Once the patient has incurred the Deductible, they are not longer responsible for the 20% payment during the duration period of the deductible.

The annual Deductible is applied to all Eligible Services provided to a Low Income Patient or Family member during the Eligibility Period. Each Family member must be determined to be a Low Income Patient in order for his or her expenses for Eligible Services to be applied to the Deductible. The health center will track the patient's Eligible Service expenses for services provided by the health center until the patient meets the Deductible. However, if more than one Family member is determined to be a Low Income Patient, or if the patient or Family members receive services from more than one Provider, it is the patient's responsibility to track the Deductible and provide documentation to the Provider that the Deductible has been reached.

613.08(1)(c)2b Policies and procedures for collecting financial information from patients

All patients who wish to apply for HSN or other public coverage are required to complete and submit a MassHealth Application using the eligibility procedures and requirements applicable to MassHealth applications.

(a) Determination Notice. The Office of Medicaid will notify the individual of his or her eligibility determination for MassHealth, Commonwealth Care, or Low Income Patient status.

(b) The Division's Electronic Free Care Application may be used for the following special application types:

a. Minors receiving Confidential Services may apply to be determined a Low Income Patient using their own income information and using the Division's Electronic Free Care Application. If a minor is determined to be a Low Income Patient, the health center will submit claims for confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process.

b. An individual seeking eligible services who has been battered or abused, or who has a reasonable fear of abuse or continued abuse, may apply for Low Income Patient status using his or her own income information. Said individual is not required to report his or her primary address.

c. An individual who is incarcerated may apply for Low Income Patient status for services provided within six months prior to his or her application.

613.08(1)(c)2c Emergency Care classification; elective or scheduled services differentiated
N/A

613.08(1)(c)2d Policy for deposits and payment plans
Patients are allowed to pay what the can afford monthly. As long as the patient is making regularly scheduled monthly payments agreed upon by Health Center and patient, the patient is deemed in good standing.
The health center's billing department provides and monitors Deposits and Payment Plans as described in **Section 5** of this policy for qualified patients as described in 101 CMR 613.08. Each payment plan must be authorized by the Billing Manager or other Health center authorized person.

613.08(1)(c)2e Copies of billing invoices and notices of assistance
See attachments

613.08(1)(c)2f Description of any discount or charity program for the uninsured
If a patient is uninsured and not eligible for any coverage, they can be put on the Health Center's Sliding Fee Scale based on their income level. They would be required to pay a copay based on their income level.

613.08(1)(c)2g Description of hospital's deductible payment option at each HLHC & satellite location, HLHC choice of full versus 20% deductible payment option for partial HSN patients, HLHC offer of 20% deductible payment option to all partial HSN patients (if chosen)
N/A

613.04(6)(c)5a CHC charge of 20% of deductible per visit to all partial HSN patients
Partial Low Income Patients receiving Reimbursable Health Services from SSTAR are responsible for 20% of the Health Safety Net payment for each visit, to be applied to the amount of the Patient's annual deductible until the Patient meets his or her deductible. Health Safety Net - Partial Low Income Patients receiving Reimbursable Health Services from Hospital Licensed Health Centers, Satellite Clinics, and school-based health centers are responsible for either 20% of the Health Safety Net payment for each visit or the full amount of the service, as specified by the Provider. If the Provider specifies that a Health Safety Net – Partial Low Income Patient is responsible for 20% of the payment amount, SSTAR may submit a claim for the remaining balance of each eligible service.

613.08(1)(c)2h Direct Website or URL where the Provider's Credit and Collection Policy, Provider Affiliate List (if applicable), and other financial assistance policies are posted
http://www.sstar.org/primary-healthcare/

613.08(1)(d) Provider Affiliate List, effective the first day of the Acute Hospital's fiscal year beginning after December 21, 2016
N/A

4. COLLECTION OF FINANCIAL INFORMATION

613.06(1)(a)1 Inpatient, Emergency, Outpatient & CHC Services
SSTAR makes reasonable efforts, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or Guarantor. When a patient fills out the intake form, they need to provide SSTAR with the name and phone number of the person financially responsible for their medical care.

613.06(1)(a)2a Inpatient Verification
N/A

613.06(1)(a)2b Outpatient/CHC verification
SSTAR makes reasonable efforts to verify patient-supplied information at the time the patient receives the services. The verification of patient-supplied information may occur at the time the patient receives the services or during the collection process as defined below:
1. Verification of gross monthly-earned income is mandatory and shall include, but not be limited to, the following:
a. Two recent pay stubs;
b. A signed statement from the employer; or
c. The most recent U.S. tax return.
2. Verification of gross monthly-unearned income is mandatory and shall include, but not be limited to, the following:
a. A copy of a recent check or pay stub showing gross income from the source;
b. A statement from the income source, where matching is not available;
c. The most recent U.S. Tax Return.
3. Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.

5. DEPOSITS & PAYMENT PLANS

613.08(1)(g)1 Deposits may not be required for Emergency Services & Low Income patients
SSTAR does not require a deposit for any services rendered at the Health Center.

613.08(1)(g)2 Deposits request from Low Income Patients
SSTAR does not require a deposit for any services rendered at the Health Center.

613.08(1)(g)3 Deposits requirement for Medical Hardship
SSTAR does not require a deposit for any services rendered at the Health Center.

613.08(1)(g)4 Interest-free Payment Plan on balance less than, and greater than, $1000
A Patient with a balance of $1,000 or less, after initial deposit, must be offered at least a one-year, interest-free payment plan with a minimum monthly payment of no more than $25. A Patient with a balance of more than $1,000, after initial deposit, must be offered at least a two-year, interest-free payment plan.

6. POPULATIONS EXEMPT FROM COLLECTION ACTION

613.08(3)(a) MassHealth and Emergency Aid to the Elderly, Disabled, and Children (EAEDC) enrollees

SSTAR does not bill patients enrolled in MassHealth, patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, except that SSTAR bills patients for any required co-payments and deductibles. SSTAR initiates billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in any of the above listed programs, and receipt of the signed application, SSTAR ceases its collection activities.

613.08(3)(b) Participants in the Children's Medical Security Plan (CMSP) with Modified Adjusted Gross Income (MAGI) income equal to or less than 300% FPL

Participants in the Children's Medical Security Plan who's MAGI is equal to or less than 300% of the FPL are also exempt from Collection Action. SSTAR initiates billing for a patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan, SSTAR ceases all collection activities.

613.08(3)(c) Low Income patient, except Dental-Only Low Income Patients

Low Income Patients, other than Dental-Only Low Income Patients, are exempt from Collection Action for any Reimbursable Health Services rendered by a Provider receiving payments from the Health Safety Net for services received during the period for which they have been determined Low Income Patients, except for copayments and deductibles. SSTAR may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients after their Low Income Patient status has expired or otherwise been terminated.

613.08(3)(d) Low Income patient with Partial HSN

Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), between 150.1 to 300% of the FPL are exempt from Collection Action for the portion of his or her Provider bill that exceeds the deductible and may be billed for copayments and deductibles as set forth in 101 CMR 613.04(6)(b) and (c). SSTAR may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients after their Low Income Patient status has expired or otherwise been terminated.

613.08(3)(e) Low Income patient consent on billing for non-Reimbursable Health Services

SSTAR bills Low Income Patients for services other than Reimbursable Health Services provided at the request of the Patient and for which the Patient has agreed to be responsible, with the exception of those services described in 101 CMR 613.08(3)(e)1. and 2. Providers must obtain the Patient's written consent to be billed for the service.

613.08(3)(e)1 Low Income patient consent exclusion for medical errors including Serious Reportable Events (SREs)

SSTAR does not bill Low Income Patients for claims related to medical errors including those described in 101 CMR 613.03(1)(d).

613.08(3)(e)2 Low Income patient consent exclusion for administrative or billing errors
SSTAR does not bill Low Income Patients for claims denied by the Patient's primary insurer due to an administrative or billing error.

613.08(3)(f) Low Income patient CommonHealth deductible billing
At the request of the Patient, SSTAR may bill a Low Income Patient in order to allow the Patient to meet the required CommonHealth One-Time Deductible as described in 130 CMR 506.009.

613.08(3)(g) Medical Hardship patient & ERBD eligible for Medical Hardship
SSTAR does not undertake a Collection Action against an individual that has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution. If a claim already submitted as Emergency Bad Debt becomes eligible for Medical Hardship payment from the Health Safety Net, SSTAR ceases collection activity on the patient for the services.

613.05 (2) Provider fails to timely submit Medical Hardship application
SSTAR will not undertake a collection action against any individual who has qualified for Medical Hardship with respect to any bills that would have been eligible for HSN payment in the event that SSTAR has not submitted the patient's Medical Hardship documentation within 5 days.

7. MINIMUM COLLECTION ACTION ON HOSPITAL EMERGENCY BAD DEBT & CHC BAD DEBT

613.06(1)(a)3bi Initial Bill
SSTAR makes the same effort to collect accounts for Uninsured Patients as it does to collect accounts from any other patient classifications.
SSTAR sends an initial bill to the party responsible for the patient's personal financial obligations.

613.06(1)(a)3bii Collection action subsequent to Initial Bill
SSTAR sends at least 4 subsequent billings, makes at least 2 telephone calls, sends collection letters that constitutes a genuine effort to contact the party responsible for the obligation.

613.06(1)(a)3biii Documentation of alternative collection action efforts
SSTAR documents alternative efforts to locate the party responsible for the obligation (such as contacting next of kin) or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable."

613.06(1)(a)3biv Final Notice by Certified Mail
SSTAR sends a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable."

613.06(1)(a)3bv Continuous collection action – no gap exceeding 120 days
When evaluating whether SSTAR has engaged in continuous Collection Action, the Health Safety Net Office may use a gap in Collection Action of greater than 120 days as a guideline for noncompliance, but may use its discretion when determining whether SSTAR has made a reasonable effort to meet the standard. If, after reasonable attempts to collect a bill, the debt for

Emergency Care for an Uninsured Patient remains unpaid for more than 120 days, SSTAR deems the bill uncollectable and may bill the Health Safety Net Office.

613.06(1)(a)3d Collection action file
The patient's file includes all documentation of SSTAR's collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made.

613.06(2) Emergency Bad Debt claim and Eligibility Verification System (EVS) check
N/A

613.06(3) HLHC Bad Debt claim and EVS check
N/A

613.06(4) CHC Bad Debt claim and EVS check
SSTAR may submit a claim for Urgent Care Bad Debt for Urgent Care Services if:
(a) the services were provided to
1. an uninsured individual who is not a Low Income Patient, unless the individual is a Dental-Only Low Income Patient. SSTAR may not submit a claim for a deductible or the coinsurance portion of a claim for which an insured Patient is responsible. SSTAR may not submit a claim unless it has checked EVS to determine if the Patient has filed an application for MassHealth; or
2. an uninsured individual whom SSTAR assists in completing an Application is determined into a category exempt from Collection Action in accordance with 101 CMR 613.08(3). Bad Debt claims for these individuals are exempt from the requirements of 101 CMR 613.06(4)(d);

(b) SSTAR provided Urgent Care Services as defined in 101 CMR 613.02 to the Patient. SSTAR may submit a claim for all Eligible Services provided during the Urgent Care Services visit, including Ancillary Services provided on site;
(c) the responsible physician determined that the Patient required Urgent Care Services. SSTAR may submit a claim for Urgent Care Services, but not for other services provided to Patients determined not to require Urgent Care Services;
(d) SSTAR undertook the required Collection Action as defined in 101 CMR 613.06(1)(a) and submitted the information required in 101 CMR 613.06(1)(b) for the account; and
(e) the bill remains unpaid after a period of 120 days of continuous Collection Action.

8. AVAILABLE THIRD PARTY RESOURCES

613.03(1)(c)3 Diligent efforts to identify & obtain payment from all liable parties
"Diligent efforts" is defined as making every effort to identify and obtain payment from all other liable parties, including insurers.

613.03(1)(c)3a Determining the existence of insurance, including motor vehicle liability
In the event that a patient seeks care for an injury, SSTAR will inquire as the existence of insurance that could pay for medical expenses by asking the Patient if he or she has other insurance and by using insurance databases available to the Provider. In the event of a motor vehicle accident, this includes investigating whether the Patient, driver, and/or owner of any motor vehicle involved had a motor vehicle liability policy;

613.03(1)(c)3b Verification of patient's other health insurance coverage
SSTAR verifies the patient's other health insurance coverage, currently known to the Health Safety Net, through EVS, or any other health insurance resource available to the SSTAR, on each date of service and at the time of billing.

613.03(1)(c)3c Submission of claims to all insurers
SSTAR submits claims to all insurers with the insurer's designated service code for the service provided.

613.03(1)(c)3d Compliance with insurer's billing and authorization requirements
SSTAR complies with the insurer's billing and authorization requirements.

613.03(1)(c)3e Appeal of denied claim
SSTAR appeals a denied claim when the service is payable in whole or in part by an insurer.

613.03(1)(c)3f Return of HSN payments upon availability of 3rd-party resources
SSTAR will immediately return any payment received from the Office when any available third-party resource has been identified.

9. SERIOUS REPORTABLE EVENTS

613.03(1)(d)1 Billing & Collection for services provided as a result of SRE
SSTAR will not charge, bill, or otherwise seek payment from the Health Safety Net, a Patient, or any other payer as required by 105 CMR 130.332: *Serious Reportable Events (SREs)*, for services provided as a result of an SRE occurring on premises covered by a Provider's license, if the Provider determines that the SRE was
a. preventable;
b. within the Provider's control; and
c. unambiguously the result of a system failure as required by 105 CMR 130.332(B): *Reporting of SREs* and (C): *Preventability Determination*.

613.03(1)(d)2 Billing & Collection for services that cause or remedy SRE
SSTAR will not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 130.332 for services directly related to:

a. The occurrence of the SRE;
b. The correction or remediation of the event; or
c. Subsequent complications arising from the event as determined by the Health Safety Net Office on a case-by-case basis.

613.03(1)(d)3 Billing & Collection by provider not associated with SRE for SRE-related services
SSTAR may submit a claim for services it provides that result from an SRE that did not occur on its premises only if the treating facility and the facility responsible for the SRE do not have common ownership or a common corporate parent.

613.03(1)(d)4 Billing & Collection for readmission or follow-up on SRE associated with provider
Readmissions to the same hospital or follow-up care provided by the same Provider or a Provider owned by the same parent organization are not billable if the services are associated with the SRE as described in 101 CMR 613.03(1)(d)2.

10. PROVIDER RESPONSIBILITIES

613.08(1)(a) Non-discrimination
SSTAR does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status.

613.08(1)(b) Board approval for legal execution against patient home or motor vehicle
SSTAR or agent thereof shall not seek legal execution against the personal residence or motor vehicle of a Low Income Patient determined pursuant to 101 CMR 613.04 without the express approval of SSTAR's Board of Trustees. All approvals by the Board must be made on an individual case basis.

613.08(1)(g) Provider responsibility to advise patient on duties and responsibilities
SSTAR will advise Patients of the responsibilities described in 101 CMR 613.08(2)(b) in all cases where the Patient interacts with registration personnel.

11. PATIENT RIGHTS & RESONSIBILITIES

613.08(2)(a)1 Provider responsibility to advise patient on right to apply for MassHealth, Health Connector programs, HSN, Medical Hardship
SSTAR advises patients Patients of the right to apply for MassHealth, the Premium Assistance Payment Program operated by the Health Connector, a Qualified Health Plan, Low Income Patient determination, and Medical Hardship.

613.08(1)(e)2a Provider responsibility to provide individual notice of Eligible Services and programs of public assistance during the Patient's initial registration with the Provider
During initial registration SSTAR will provide notice about Eligible Services and programs of public assistance, including MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, the Children's Medical Security Plan, and Medical Hardship.

613.08(1)(e)2c Provider responsibility to provide individual notice of Eligible Services and programs of public assistance when a Provider becomes aware of a change in the Patient's eligibility or health insurance coverage
SSTAR will provide notice about Eligible Services and programs of public assistance, including MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, the

Children's Medical Security Plan, and Medical Hardship when SSTAR becomes aware of a change in the patient's eligibility or health insurance coverage.

613.08(2)(a)2 Provider responsibility to advise patient on right to a payment plan
SSTAR advises patients of the right to a payment plan, as described in 101 CMR 613.08(1)(f), if the Patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

613.08(2)(b)1 Provider responsibility to advise patient on duty to provide all required documentation
SSTAR advises the patient who receives eligible services must provide all required documentation at the time of application for coverage.

613.08(2)(b)2 Provider responsibility to advise patient on duty to inform of change in eligibility status & available TPL
SSTAR advises the patient to inform MassHealth of any changes in MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), or insurance status, including but not limited to, income, inheritances, gifts, distributions from trusts, the availability of health insurance, and third-party liability. The Patient may, in the alternative, provide such notice to the Provider that determined the Patient's eligibility status.

613.08(2)(b)3 Provider responsibility to advise patient on duty to track patient deductable
SSTAR advises the patient to track the Patient Deductible and provide documentation to the Provider that the Deductible has been reached when more than one Premium Billing Family Group member is determined to be a Low Income Patient or if the Patient or Premium Billing Family Group members receive Eligible Services from more than one Provider.

613.08(2)(b)4 Provider responsibility to advise patient on duty to inform Division/MassHeath of any TPL claim/lawsuit
SSTAR advises the patient to inform the Health Safety Net Office or the MassHealth agency when the Patient is involved in an accident, or suffers from an illness or injury, or other loss that has or may result in a lawsuit or insurance claim.

613.08(2)(b)4a Provider responsibility to advise patient on duty to file TPL claim on accident, injury or loss
SSTAR advises the patient to file a claim for compensation if available.

613.08(2)(b)4bi Provider responsibility to advise patient on assessing right to recover HSN payments from TPL claim proceeds
SSTAR advises the patient to agree to comply with all requirements of M.G.L. c. 118E, including but not limited to
i. assigning to the Health Safety Net Office the right to recover an amount equal to the Health Safety Net payment provided from the proceeds of any claim or other proceeding against a third party.

613.08(2)(b)4bii Provider responsibility to advise patient on duty to provide TPL claim or proceeding information
SSTAR advises the patient to provide information about the claim or any other proceeding, and fully cooperating with the Health Safety Net Office or its contractor, unless the Health Safety Net Office determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to, the Patient.

613.08(2)(b)4biii Provider responsibility to advise patient on duty to notify Division/MassHealth within 10 days of filing TPL claim/lawsuit
SSTAR advises the patient to notify the Division or MassHealth in writing within 10 days of filing any claim, civil action, or other proceeding.

613.08(2)(b)4biv Provider responsibility to advise patient on duty to repay HSN for applicable services from TPL proceeds
SSTAR advises patient to repay the Health Safety Net from the money received from a third party for all Health Safety Net eligible services provided on or after the date of the accident or other incident after becoming a Low Income Patient for purposes of Health Safety Net payment, only Health Safety Net payment provided as a result of the accident or other incident will be repaid.

613.08(1)(e)1a Provider responsibility to provide individual notice of financial assistance during the Patient's initial registration with the Provider
SSTAR will provide individual notice of the availability of financial assistance programs to a Patient expected to incur charges, exclusive of personal convenience items or services, whose services may not be paid in full by third party coverage during the patient's initial registration with the Provider.

613.08(1)(e)1c Provider responsibility to provide individual notice of financial assistance when a Provider becomes aware of a change in the Patient's eligibility or health insurance coverage
SSTAR will provide individual notice of the availability of financial assistance programs to a Patient expected to incur charges, exclusive of personal convenience items or services, whose services may not be paid in full by third party coverage when SSTAR becomes aware of a change in the patient's eligibility or health insurance coverage.

613.08(2)(c) Provider responsibility to advise patient of HSN limit on recovery of TPL claim proceeds
SSTAR advises the patient that The Health Safety Net Office only recovers sums directly from a Patient to the extent that the Patient has received payment from a third party for the medical care paid by the Health Safety Net or to the extent specified in 101 CMR 613.06(5).

12. SIGNS

613.08(1)(f)1 Location of the signs
SSTAR has signs posted in the waiting room area, front office area and Health Access area that conspicuously inform patients of the availability of financial assistance programs and who to speak with to apply for such programs.

613.08(1)(f)1 Size of the signs
SSTAR's signs are 8x11.5 inches, which is large enough to be clearly visible and legible by patients visiting these areas.

613.08(1)(f)1 Multi-lingual signs when applicable
All signs and notices must be translated into language(s) other than English if such language(s) is primarily spoken by 10% or more of the residents in the Provider's service area. – *N/A, SSTAR does not have one language other than English that is spoken by 10% or more of the patients.*

613.08(1)(f)1 Wording in signs
Signs must notify patients of the availability of financial assistance and of other programs of public assistance. The following language is used in SSTAR's signs:
If you are unable to pay your bill, financial assistance is available.
Please ask to speak with Health Access if you do not have insurance or the billing department if you are unable to pay your patient balance.

613.08(1)(f)2 Providers must make their Credit and Collection Policy and Provider Affiliate List (if applicable) available on the Provider's website
SSTAR's Credit and Collection Policies filed in accordance with 101 CMR 613.08(1)(c)1. and Provider Affiliate lists (if applicable), as described in 101 CMR 613.08(1)(d), is available on the SSTAR's website: http://www.sstar.org/primary-healthcare/

13. SAMPLE DOCUMENTS & NOTICES ON AVAILABILITY OF ASSISTANCE

613.08(1)(e)1b Sample of assistance notice on billing invoice
SSTAR will provide individual notice of the availability of financial assistance programs, including Medical Hardship, to a Patient expected to incur charges, exclusive of personal convenience items or services, which may not be paid in full by third party coverage.
See attachment "refer to health access"

613.08(1)(e)2b Sample of Eligible Services and programs of assistance notice on billing invoice
SSTAR includes a notice about Eligible Services to Low Income Patients and programs of public assistance in its initial bill.
See attachment "sample bill"

613.08(1)(e)3 Sample of assistance notice in collection actions (billing invoices)
SSTAR includes a brief notice about Eligible Services to Low Income Patients in all written Collection Actions – see attachment "balance due letter to patients"

613.08(1)(e)4 Sample of payment plan notice to Low Income or Medical Hardship patients
SSTAR notifies the Patient that SSTAR offers a payment plan as described in 101 CMR 613.08(1)(f), if the Patient is determined to be a Low Income Patient or qualifies for Medical Hardship - see attachment "balance due letter to patients"

613.08(1)(f) Posted Signs See attachment "if you are unable to pay your bill"