COLORADO
Department of Health Care Policy & Financing

303 E. 17th Ave. Suite 1100
Denver, CO 80203

# Hospital Discounted Care Data Reporting Template Instructions for Facilities

## Instructions for Proper Data Entry

Below are instructions for identifying and managing data entry within the template.

**Completing Required Sheets:**

**Write-Off Attestation**

Provide attestation to whether or not Hospital Discounted Care (HDC) patient balances are being written off completely. Additionally, provide the name of the attestant.

**Hospital Totals**

Provide total aggregate numbers for all data elements. Each column lists whether patients should be duplicated or not within the total counts.

Column A. Facility ID * (Required) – Provide the main hospital Facility ID

Column B. Total Screenings Completed for Uninsured Patients * (Required) – Provide the total number of screenings completed for uninsured patients, including multiples if the patient was screened more than once during the state fiscal year (July to June)

Column C. Total Decline Screening Forms Completed for Uninsured Patients * (Required) – Provide the total number of Decline Screening forms completed by uninsured patients, including multiples if the patient signed more than one Decline Screening forms during the state fiscal year (July to June)

Column D. Total Applications Completed for Uninsured Patients * (Required) – Provide the total number of applications completed for uninsured patients, including multiples if the patient completed more than one application during the state fiscal year (July to June)

Column E. Total Uninsured Patients who were not screened and did not formally decline screening * (Required) – Provide the total number of unique patients who did not complete screening nor formally declined screening

Column F. Total Screenings Completed for Insured Patients * (Required) – Provide the total number of screenings completed for insured patients, including multiples if the patient was screened more than once during the state fiscal year (July to June)

Column G. Total Applications Completed for Insured Patients * (Required) – Provide the total number of applications completed for insured patients, including multiples if the patient completed more than one application during the state fiscal year (July to June)

Column H. Total number of uninsured patients who received a payment plan * (Required) – Provide the total number of unique uninsured patients who received during the state fiscal year (July to June)

Column I. Total number of payment plans created for uninsured patients * (Required) – Provide the total number of payment plans created for uninsured patients, including multiples if a patient received multiple payment plans during the state fiscal year (July to June)

Column J. Total number of payment plans paid in full prior to the cumulative thirty-six months of payments for uninsured patients * (Required) – Provide the total number of payment plans completed due to the uninsured patient completing their payment plan prior to the originally set end date

Column K. Total number of payment plans paid in full due to cumulative thirty-six months of payments reached for uninsured patients * (Required) – Provide the total number of payment plans completed due to the uninsured patient completing their payment plan in the original number of payments

Column L. Total number of insured patients who received a payment plan * (Required) – Provide the total number of unique insured patients who received during the state fiscal year (July to June)

Column M. Total number of payment plans created for insured patients * (Required) – Provide the total number of payment plans created for insured patients, including multiples if a patient received multiple payment plans during the state fiscal year (July to June)

Column N. Total number of payment plans paid in full prior to the cumulative thirty-six months of payments for insured patients * (Required) – Provide the total number of payment plans completed due to the insured patient completing their payment plan prior to the originally set end date

Column O. Total number of payment plans paid in full due to cumulative thirty-six months of payments reached for insured patients * (Required) – Provide the total number of payment plans completed due to the insured patient completing their payment plan in the original number of payments

Column P. Total number of accounts for uninsured patients sent to collections by Facility * (Required) – Provide the total number of accounts for uninsured patients sent to collections by the Facility, including multiples if more than one account was sent to collections during the state fiscal year (July to June)

Column Q. Total number of accounts for uninsured patients sent to collections by Professionals # (Required if you choose to report data for Professionals) – Provide the total number of accounts for uninsured patients sent to collections by Professionals, including multiples if more than one account was sent to collections during the state fiscal year (July to June)

Column R. Smallest account balance sent to collections for uninsured patients * (Required) – Provide the smallest account balance that was sent to collections for uninsured patients during the state fiscal year (July to June)

Column S. Average account balance sent to collections for uninsured patients * (Required) – Provide the average account balance that was sent to collections for uninsured patients during the state fiscal year (July to June)

Column T. Largest account balance sent to collections for uninsured patients * (Required) – Provide the largest account balance that was sent to collections for uninsured patients during the state fiscal year (July to June)

Column U. Total number of accounts for insured patients sent to collections by Facility * (Required) – Provide the total number of accounts for insured patients sent to collections by the Facility, including multiples if more than one account was sent to collections during the state fiscal year (July to June)

Column V. Total number of accounts for insured patients sent to collections by Professionals # (Required if you choose to report data for Professionals) – Provide the total number of accounts for insured patients sent to collections by Professionals, including multiples if more than one account was sent to collections during the state fiscal year (July to June)

Column W. Smallest account balance sent to collections for insured patients * (Required) – Provide the smallest account balance that was sent to collections for insured patients during the state fiscal year (July to June)

Column X. Average account balance sent to collections for insured patients * (Required) – Provide the average account balance that was sent to collections for insured patients during the state fiscal year (July to June)

Column Y. Largest account balance sent to collections for insured patients * (Required) – Provide the largest account balance that was sent to collections for insured patients during the state fiscal year (July to June)

**Patient Demographics**

Provide the patient demographics for each patient who was screened, completed a declined screening form, or completed an application for HDC. Patients should only appear in this sheet once, unless they have multiple screenings, declined screenings, or completed applications with different insurance statuses.

NOTE: The following columns will flag as red once an MRN is entered in Column B: Facility ID, Race, Ethnicity, DOB, Preferred Language, Insurance Status. The Race, Ethnicity, and Insurance Status columns need to match the expected values listed for each below. If you encounter issues, please consult the Trouble Shooting Sheet.

Column A. Facility ID * (Required) - Provide the main Facility ID or Facility ID where the patient completed HDC screening or application; the cells in this column will be red if a Facility ID is not entered but information is entered in Column B - Medical Record Number in the same row.

Column B. Medical Record Number (MRN) * (Required) - Provide the Medical Record Number for the Patient.

Column C. Race * (Required) - Provide the Race for the patient from the following list: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino,

Middle Eastern or North African, Native Hawaiian or Pacific Islander, White, Declined, Other, Two or More Races, or Unknown.

Column D. Ethnicity * (Required) - Provide the Ethnicity of the patient from the following list: Hispanic or Latino, Not Hispanic or Latino, Declined, or Unknown.

Column E. DOB * (Required) - Provide the Date of Birth (DOB) of the patient.

Column F. Preferred Language * (Required) - Provide the preferred language of the patient.

Column G. Insurance Status * (Required) - Provide the insurance status of the patient from the following list: Insured, Uninsured, Unknown, or Declined.
Column H. Patient Zip Code (Optional) - Provide the patient's Zip Code.

Column I. Patient State (Optional) - Provide the patient's State.

Column J. Patient County (Optional) - Provide the patient's county.

**Screening-Application**

Provide all screening, decline screening, and application information for all uninsured patients and all insured patients who requested and/or completed a screening or application for financial assistance.

NOTE: The following columns will flag as red once an MRN is entered in Column B: Facility ID, Final Determination (HDC, CICP, or Internal Charity Care)

Column A. Facility ID * (Required) - Provide the main Facility ID or Facility ID where the patient completed HDC screening or application; the cells in this column will be red if a Facility ID is not entered but information is entered in Column B - Medical Record Number in the same row.

Column B. Medical Record Number (MRN) * (Required) - Provide the Medical Record Number for the Patient; the cells in this column will be red if there is not a matching Medical Record Number (MRN) entered in the Patient Demographics tab

Column C. Encounter Number (Optional) - Provide the patient's encounter, account, or visit number for the encounter, account, or visit.

Column D. Date of Service (Optional) - Provide the date the patient received service or started to receive service if inpatient.

Column E. Date of Discharge (Optional) - Provide the date the patient was discharged.

Column F. Date of Screening (Optional) - Provide the date the patient was screened for HDC.

Column G. Date Decline Screening Form Signed (Optional) - Provide the date the patient signed the "Decline Screening" form.

Column H. Date Application Started (Optional) - Provide the date the patient's HDC application was started.

Column I. Date Application Completed (Optional) - Provide the date the patient's HDC application was completed.

Column J. FPG % Determination (Optional) - Provide the Federal Poverty Guideline Percentage Determination for the patient.

Column K. Screening Status* (Required) - Provide the current status of this patient's screening from the following list: Completed, In Process, Patient Unresponsive, Declined.

Column L. Final Determination (HDC, CICP, or Internal Charity Care) * (Required) - Provide the final determination for the patient from the following list: Medicaid, Hospital Discounted Care/CICP, Individual Hospital Charity Program, Self Pay, No Final Determination.

Column M. Reason for Hospital Discounted Care Denial (If Applicable) # (Required if patient was denied) - Provide the reason the patient was denied for HDC, only required if the patient was denied for HDC.

**Visit-Admission-Charges**

Provide visit and admission information for all uninsured patients and all insured patients who qualified for financial assistance.

NOTE: The following columns will flag as red once an MRN is entered in Column B: Facility ID, Facility Charges, Hospital Discounted Care Allowed Amount, Patient Liability.

Column A. Facility ID * (Required) – Provide Facility ID for location where the patient received services; the cells in this column will be red if a Facility ID is not entered but information is entered in Column B - Medical Record Number in the same row

Column B. Medical Record Number (MRN) * (Required) – Provide the patient's unique Medical Record Number (MRN); the cells in this column will be red if there is not a matching Medical Record Number (MRN) entered in the Patient Demographics tab

Column C. Encounter Number (Optional) – Provide the patient's encounter, account, or visit number

Column D. Outpatient or Inpatient (Optional) – Provide information on whether the encounter, account, or visit was outpatient or inpatient

Column E. Number of Inpatient Days (Only if Inpatient)# (Required if Inpatient) – Provide the number of days the patient was admitted, must be at least 1 day – do NOT enter zeros for outpatient visits or inpatient admissions; Note that patients who are in observation are counted as an outpatient if their observation lasts less than 24 hours and an inpatient if their observation lasts 24 hours or more.

Column F. Facility Charges * (Required) – Provide the Facility's usual charges for the encounter, account, or visit; the cells in this column will be red if an amount is not entered but information is entered in Column B - Medical Record Number in the same row

Column G. Hospital Discounted Care Allowed Amount * (Required) – Provide the amount allowed under Hospital Discounted Care for the encounter, account, or visit; Facilities that are writing off accounts fully should enter 0 in this column for all encounters, accounts, or visits; the cells in this column will be red if an amount is not entered but information is entered in Column B - Medical Record Number in the same row

Column H. Third Party Liability (If Applicable) # (If amount due or received) – Provide the amount due or received from any third party associated with the encounter, account, or visit

Column I. Patient Liability * (Required) – Provide the amount due from the patient for the encounter, account, or visit; Facilities that are writing off accounts fully should enter 0 in

this column for all encounters, accounts, or visits; the cells in this column will be red if an amount is not entered but information is entered in Column B - Medical Record Number in the same row

**Payment Plans - This tab should only be filled out for Facilities at Physicians who are not fully writing off accounts for Hospital Discounted Care patients.**

Provide information on all payment plans that were active during the state fiscal year (July through June) for patients who have a payment plan under Hospital Discounted Care. A payment plan consists of two or more payments as agreed to by the patient and the facility and should not include information on patients who paid their full patient liability in one payment.

NOTE: The following columns will flag as red once an MRN is entered in Column B: Facility ID, Total Amount of Payment Plan, Amount written off at end of Payment Plan.

Column A. Facility ID * (Required) – Provide Facility ID for location that created the payment plan, or main Facility ID if accounts from multiple locations were included in the payment plan; the cells in this column will be red if a Facility ID is not entered but information is entered in Column B - Medical Record Number in the same row

Column B. Medical Record Number (MRN) * (Required) – Provide the patient's unique Medical Record Number (MRN); the cells in this column will be red if there is not a matching Medical Record Number (MRN) entered in the Patient Demographics tab

Column C. Encounter Number (Optional) – Provide the patient's encounter, account, or visit number for the encounter, account, or visit included in the payment plan

Column D. Date of Service (Optional) – Provide the date of service for the encounter, account, or visit included in the payment plan

Column E. Date Payment Plan Established (Optional) – Provide the date that the payment plan was created or established

Column F. Total Amount of Payment Plan * (Required) – Provide the total amount of the payment plan on the date it was established or created; the cells in this column will be red if an amount is not entered but information is entered in Column B – Medical Record Number (MRN) in the same row

Column G. Date Payment Plan Completed (Optional) – Provide the date on which the patient made their final payment to complete their payment plan

Column H. Amount written off at end of Payment Plan * (Required) – Provide the amount that the Facility or Physician has or will be writing off at the end of the patient's established payment plan; the cells in this column will be red if an amount is not entered but information is entered in Column B – Medical Record Number (MRN) in the same row

**Collections - This tab should only be filled out for Facilities at Physicians who are not fully writing off accounts for Hospital Discounted Care patients.**

Provide information on all accounts for services provided to patients who were determined eligible for Hospital Discounted Care that were assigned or sold to collections during the state fiscal year (July through June) from both the hospital as well as any non-employed physicians or physician groups.

NOTE: The following columns will flag as red once an MRN is entered in Column B: Facility ID, Facility or Physician Name, Amount of Account sent to Collections.

Column A. Facility ID * (Required) – Provide Facility ID for location that sent account to collections, or main Facility ID if accounts from multiple locations sent to collections; the cells in this column will be red if a Facility ID is not entered but information is entered in Column B - Medical Record Number in the same row

Column B. Medical Record Number (MRN) * (Required) – Provide the patient's unique Medical Record Number (MRN); the cells in this column will be red if there is not a matching Medical Record Number (MRN) entered in the Patient Demographics tab

Column C. Encounter Number (Optional) – Provide the patient's encounter, account, or visit number for the encounter, account, or visit sent to collections

Column D. Date of Service (Optional) – Provide the date of service for the encounter, account, or visit sent to collections

Column E. Date Patient was notified of any collection actions (Optional) – Provide the date the patient was first notified that they were in danger of being sent to collections for this encounter, account, or visit

Column F. Date Sent to Collections (Optional) – Provide the date the encounter, account, or visit was assigned or sold to collections

Column G. Collection Agency Debt Sold To (Optional) – Provide the name of the collection agency the encounter, account, or visit was assigned or sold to

Column H. Facility or Professional Name * (Required) – Provide the name of the Facility, Provider, Professional, or Group that assigned or sold the encounter, account, or visit to collections; the cells in this column will be red if the Facility or Professional Name is not entered but information is entered in Column B - Medical Record Number in the same row

Column I. Health Care Professional In or Out of Network (Optional) – If the encounter, account, or visit was sent to collections by a Physician or Physician Group, provide whether the Physician or Physician Group was in or out of network for the patient if the patient had a third party payer

Column J. Hospital Discounted Care Allowed Amount (Optional) – Provide the total allowed amount under Hospital Discounted Care for the encounter, account, or visit that was assigned or sold to collections

Column K. Third Party Name (Optional) – Provide the name of any third party payer associated with the encounter, account, or visit that was assigned or sold to collections

Column L. Amount of Third Party Payment # (Required if Applicable) – Provide the amount received or due from any third party payer associated with the encounter, account, or visit that was assigned or sold to collections

Column M. Date of Third Party Payment (Optional) – Provide the date that any payment was received from any third party payer associated with the encounter, account, or visit that was assigned or sold to collections

Column N. Third Party Copay Amount (Optional) – Provide the patient's copay amount per any third party payer associated with the encounter, account, or visit that was assigned or sold to collections

Column O. Third Party Deductible Amount (Optional) – Provide the patient's deductible amount per any third party payer associated with the encounter, account, or visit that was assigned or sold to collections

Column P. Total Amount of Patient Payments (Optional) – Provide the total amount of payments received from the patient for the encounter, account, or visit that was assigned or sold to collections

Column Q. Amount of Account sent to Collections * (Required) – Provide the total amount sent to collections of the encounter, account, or visit that was assigned or sold to collections; the cells in this column will be red if an amount is not entered but information is entered in Column B - Medical Record Number in the same row

**Completing Optional Sheets:**

**Hospital and Satellites**

Provide information for the hospital and all satellites at which Hospital Discounted Care and/or CICP services are being provided to qualified patients.

Column A. Facility ID# (Required if completing the Hospital and Satellites Sheet) - Provide the Facility ID for each hospital or satellite being included in the report.

Column B. Facility Legal Name (Optional) - Provide the legal name for each hospital or satellite location being included in the report.

Column C. Facility DBA (Optional) - If different than the legal name, provide the Doing Business As (DBA) name for each hospital or satellite being included in the report.

Column D. Facility Address (Optional) - Provide the street address for each hospital or satellite location being included in the report.

Column E. Facility Zip (Optional) - Provide the zip code for each hospital or satellite location being included in the report.

Column F. Facility County (Optional) - Provide the county for each hospital or satellite location being included in the report.

Column G. Main or Satellite (Optional) - Provide the designation of "Main" or "Satellite" for each location being included in the report.

**Providers-Professionals-Groups**

Provide each unique Professional or Group once, even if the Professional or Group provided services at multiple facilities.

Column A. Facility ID# (Required if completing the Providers-Professionals-Groups Sheet) - Provide the Facility ID for each hospital or satellite where Non-Employed Professionals or Groups provided Hospital Discounted Care (HDC) services.

Column B. Name of Non-Employed Providers/Professionals/Groups# (Required if completing the Physicians Sheet) - Provide the name for each Non-Employed Professional or Group that provided HDC services at a Facility ID being included in the report.

Column C. Address (Optional) - Provide the street address for each Non-Employed Professional or Group that provided HDC services at a Facility ID being included in the report.

Column D. County (Optional) - Provide the county for each Non-Employed Professional or Group that provided HDC services at a Facility ID being included in the report.

Column E. Zip (Optional) - Provide the zip code for each Non-Employed Professional or Group that provided HDC services at a Facility ID being included in the report.

Column F. Phone Number or Email (Optional) - Provide the Phone Number or Email for each Non-Employed Professional or Group that provided HDC services at a Facility ID being included in the report.

**Collection Agencies**

Provide each unique Collection Agency or Group only once, not for each individual claim or location.

Column A. Facility ID# (Required if completing the Collection Agencies Sheet) - Provide the Facility ID for each hospital or satellite that sent a HDC debt to collections.

Column B. Collection Agency Name/Group # (Required if completing the Collection Agencies Sheet) - Provide the name for each Collection Agency or Group that the hospital sent a HDC debt to.

Column C. Address (Optional) - Provide the street address for each Collection Agency or Group that the hospital sent a HDC debt to.

Column D. County (Optional) - Provide the county for each Collection Agency or Group that the hospital sent a HDC debt to.

Column E. Zip (Optional) - Provide the zip code for each Collection Agency or Group that the hospital sent a HDC debt to.

Column F. Phone Number (Optional) - Provide the Phone Number for each Collection Agency or Group that the hospital sent a HDC debt to.

**Third Parties**

Provide each unique Third Party Payer only once, not for each individual claim or location.

Column A. Facility ID# (Required if completing the Third Parties Sheet) - Provide the Facility ID for each hospital or satellite where Third Party Payers were responsible for payments for patients that qualified for HDC.

Column B. Third Party Payer Name/Group # (Required if completing the Third Parties Sheet) - Provide the name for each Third Party Payer who was responsible for payments for patients that qualified for HDC.

Column C. Address (Optional) - Provide the street address for each Third Party Payer who was responsible for payments for patients that qualified for HDC.

Column D. County (Optional) - Provide the county for each Third Party Payer who was responsible for payments for patients that qualified for HDC.

Column E. Zip (Optional) - Provide the zip code for each Third Party Payer who was responsible for payments for patients that qualified for HDC.

Column F. Phone Number (Optional) - Provide the Phone Number for each Third Party Payer who was responsible for payments for patients that qualified for HDC.

Column G. In or Out of Network (Optional) - Provide the designation of "In Network" or "Out of Network" for each Third Party Payer who was responsible for payments for patients that qualified for HDC.

## Troubleshooting Data Validation Errors

The report template has formatting built in to identify if a required data element is missing. On some columns, it will also have formatting built in to identify data elements that are not valid entries for the column in which it was entered. If a missing or invalid data element is detected, the cell will turn red, flagging that it is not an acceptable entry. Columns with these validation requirements are listed below:

**Table 1. Correct Entries for Patient Demographics Tab**

| Race* | Ethnicity* | Insurance Status* |
|---|---|---|
| American Indian or Alaska Native | Hispanic or Latino | Insured |
| Asian | Not Hispanic or Latino | Uninsured |
| Black or African American | Unknown | Unknown |
| Declined | Declined | Declined |
| Hispanic or Latino | | |
| Middle Eastern or North African | | |
| Native Hawaiian or Pacific Islander | | |
| Other | | |
| Two or More Races | | |
| Unknown | | |
| White | | |

**Table 2. Correct Entries for Screening Application Tab**

| Screening Status* | Final Determination (HDC,CICP, or Internal Charity Care)* |
|---|---|
| Completed | Hospital Discounted Care/CICP |
| Declined | Individual Hospital Charity Program |
| In Process | Medicaid |
| Patient Unresponsive | Self Pay |
| | No Final Determination |

**Patient Demographics***

Race* - alpha from the race column in Table 1. Correct Data Entries for Patient Demographics Tab.

- Race categories were selected using the five minimum categories outlined in OMB standards for the 2020 census. Two or More Races, Other, Unknown, and Declined were added for those who did not fit in one of the categories or declined to provide information.

- https://www.census.gov/newsroom/blogs/random-samplings/2024/04/updates-race-ethnicity-standards.html

Ethnicity* - alpha from the Ethnicity column in Table 1. Correct Data Entries for Patient Demographics Tab.

- For ethnicity, the OMB standards classified individuals in one of two categories: “Hispanic or Latino” or “Not Hispanic or Latino.” Starting March of 2024, OMB has removed the ethnicity category. We have kept it for this year since Hospital systems might not be updated for such a recent change and we have added the Unknown and Declined categories for if a patient's ethnicity is not know or withheld.

- https://www.census.gov/newsroom/blogs/random-samplings/2021/08/measuring-racial-ethnic-diversity-2020-census.html

DOB* - Dates from 1/1/1900 through 9/1/2025 are accepted.

Insurance Status* - alpha from the Insurance Status column in Table 1. Correct Data Entries for Patient Demographics Tab.

**Screening Application***

Screening Status* - varchar from the Screening Status* column on Table 2. Correct Entries for the Screening-Application Tab.

Final Determination (HDC, CICP, Internal Charity, etc.)* - varchar from the Final Determination (HDC, CICP, or Internal Charity Care)* column in Table 2. Correct Entries for the Screening-Application Tab.

Visit-Admission-Charges*

Number of days if Inpatient (Only if Inpatient)# - Value must be between 1 day and 365 days

Patient Liability* - If patient liability is written off, write as $0

**How to Identify Data Validation Flags and Replace Them**

To identify invalid required(blue) data elements within this template, you will need to make use of Excel's filtering functionality. Please follow the following steps:

1. Click the arrow dropdown icon in the column header where you need to correct entries.

2. Hover your mouse over the "Filter By Color" option and then click the red rectangle that should pop out on the right. This will allow you to show only rows that have an invalid data entry for this column, allowing you to more quickly address the error.

3. If needed, you can add further filtering to single out repeated errors.

4. Once you have the error identified, you can copy the correct format for the data value from Table 1 or Table 2 (shown on the right) and paste the corrected entry over any incorrect entries.

**"Why is this cell showing red?"**

There are 3 primary reasons why a cell might show red within this template. They are as follows:

- For Medical Record Number (MRN) Columns, if the MRN does not match an MRN that was entered into the 'Patent Demographics*' Tab, it will flag red

- If a required cell is left blank after entering an MRN into that row, it will flag red

- If a required cell is given an invalid entry after entering an MRN into that row, it will flag red. See above for valid entry options.

## Data Type Definitions

For each sheet, as well as columns within those sheets, blue data elements are required (columns will also have stars*); Green data elements are conditionally required (columns will have pound signs '#' and the listed conditions under which they are required); Grey data elements are optional.

Below is a breakout of each sheet as well as each column that will appear on each sheet. We have listed the requested data format for each column to prevent issues with the data. Please also see the definitions for various data types used in this template:

Varchar = various characters, letters and/or numbers

Numeric = numbers only

Alpha = letters only

Phone number = 10-digit phone number

Integer = whole numbers, no decimals

Dollar amount = dollars, either with or without cents

Date = mm/dd/yyyy (time stamp is not needed)

**Hospital and Satellites**

Facility ID (Required if Filled)# - Medicare, Medicaid, NPI, etc.

Facility Legal Name - varchar

Facility DBA - varchar

Facility Address - varchar

Facility Zip - numeric

Facility County - varchar (County name or CICP County number)

Main or Satellite – alpha

**Providers-Professionals-Groups**

Facility ID (Required if Filled)# - Medicare, Medicaid, NPI, etc.

- ID for facility professional provided services in, if multiple use hospital ID

Non-Employed Provider/Professional/Group (Required if Filled)# - varchar

- Do not need to name all individual professionals of a group

Address - varchar

County - varchar (County name or CICP County number)

Zip - numeric

Phone Number or Email - varchar

**Collection Agencies**

Facility ID (Required if Filled)# - Medicare, Medicaid, NPI, etc.

- ID for facility professional provided services in, if multiple use hospital ID

Collection Agency Name/Group - varchar

Address - varchar

County - varchar (County name or CICP County number)

Zip - numeric

Phone Number - phone number

**Third Parties**

Facility ID (Required if Filled)# - Medicare, Medicaid, NPI, etc.

- ID for facility professional provided services in, if multiple use hospital ID

Third Party Payer Name/Group - varchar

Address - varchar

County - varchar (County name or CICP County number)

Zip - numeric

Phone Number - phone number

In or Out of Network - alpha

- Choices are In, Out, or N/A for those where network does not apply

**Write-Off Attestation***

Please attest to whether or not your facilities write off the balances for Hospital Discounted Care Patients* - Indicate Yes or No

Name of Attestant* - varchar

**Hospital Totals***

Facility ID* - Medicare, Medicaid, NPI, etc.

- ID for facility professional provided services in, if multiple use hospital ID

Total Screenings Completed for Uninsured Patients* - integer

Total Decline Screening Forms Completed for Uninsured Patients* - integer

Total Applications Completed for Uninsured Patients* - integer

Total Uninsured Patients who were not screened and did not formally decline screening* - integer

Total Screenings Completed for Insured Patients* - integer

Total Applications Completed for Insured Patients* - integer

Total number of uninsured patients who received a payment plan* - integer

Total number of payment plans created for uninsured patients* - integer

Total number of payment plans paid in full prior to the cumulative thirty-six months of payments for uninsured patients* - integer

Total number of payment plans paid in full due to cumulative thirty-six months of payments reached for uninsured patients* - integer

Total number of insured patients who received a payment plan* - integer

Total number of payment plans created for insured patients* - integer

Total number of payment plans paid in full prior to the cumulative thirty-six months of payments for insured patients* - integer

Total number of payment plans paid in full due to cumulative thirty-six months of payments reached for insured patients* - integer

Total number of accounts for uninsured patients sent to collections by Facility* - integer

Total number of accounts for uninsured patients sent to collections by Professionals# - integer

Smallest account balance sent to collections for uninsured patients* - dollar amount

Average account balance sent to collections for uninsured patients* - dollar amount

Largest account balance sent to collections for uninsured patients* - dollar amount

Total number of accounts for insured patients sent to collections by Facility* - integer

Total number of accounts for insured patients sent to collections by Professionals# - integer

Smallest account balance sent to collections for insured patients* - dollar amount

Average account balance sent to collections for insured patients* - dollar amount

Largest account balance sent to collections for insured patients* - dollar amount

**Patient Demographics***

Facility ID* - Medicare, Medicaid, NPI, etc.

- ID for facility professional provided services in, if multiple use hospital ID

Medical Record Number (MRN)* - varchar

Encounter Number - varchar

Race* - alpha from the following list: [Black or African American, White, Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, Two or More Races, Other, Unknown, Declined]

- Race categories were selected using the five minimum categories outlined in OMB standards for the 2020 census. Two or More Races, Other, Unknown, and Declined were added for those who did not fit in one of the categories or declined to provide information.

- https://www.census.gov/newsroom/blogs/random-samplings/2024/04/updates-race-ethnicity-standards.html

Ethnicity* - alpha from the following list: [Hispanic or Latino, Not Hispanic or Latino, Unknown, Declined]

- For ethnicity, the OMB standards classified individuals in one of two categories: “Hispanic or Latino” or “Not Hispanic or Latino.” Starting March of 2024, OMB has removed the ethnicity category. We have kept it for this year since Hospital systems might not be updated for such a recent change and we have added the Unknown and Declined categories for if a patient's ethnicity is not known or withheld.

DOB* - Dates from 1/1/1900 through 9/1/2024 are accepted.

Preferred Language* - alpha from the following list: [English, Spanish, Amharic, Arabic, French, Russian, Ukranian, Other, Unknown, Declined]

- Language categorizations were determined by taking the data submitted last year and selecting all languages that had a count of over 100 patients. From there we added Other, Unknown, and Declined in case a patient does not fit into any of the listed categories.

Insurance Status* - alpha from the follwing list: [Insured, Uninsured, Unknown]

Patient Zip Code - number

Patient State- alpha

Patient County - varchar (County name or CICP County number)

**Screening Application***

Facility ID* - Medicare, Medicaid, NPI, etc.

- ID for facility professional provided services in, if multiple use hospital ID

Medical Record Number (MRN)* - varchar

- This column will flag red if there is a medical record number that does not appear in the Patient Demographics* sheet. Please try to ensure that each patient shows up on both sheets.

Encounter Number - varchar

Date of Service - date

Date of Discharge - date

Date of Screening - date

Date Decline Screening form Signed - date

Date Application Started - date

Date Application Completed - date

FPG % Determination - integer

- Number as a percentage, even if over 250%

- Can also use "Denied"/"Ineligible" if over 250%

Screening Status* - varchar from the following list: [Completed, Declined, In Process, Patient Unresponsive]

Final Determination (HDC, CICP, Internal Charity, etc.)* - varchar from the following list: [Insured, Uninsured, Medicaid, Hospital Discounted Care/CICP, Individual Hospital Charity Program, Self Pay, No Final Determination]

Reason for Denial# - varchar

- Over income, No response to contact attempts, Did not submit all required documentation, etc.

**Visit Admission Charges***

Facility ID* - Medicare, Medicaid, NPI, etc.

- ID for facility professional provided services in, if multiple use hospital ID

Medical Record Number (MRN)* - varchar

- This column will flag red if there is a medical record number that does not appear in the Patient Demographics* sheet. Please try to ensure that each patient shows up on both sheets

Encounter Number - varchar

Outpatient or Inpatient - varchar

Number of days if Inpatient* - integer

Facility Charges* - dollar amount

Medicare/Medicaid Allowed Amount* - dollar amount

Third Party Liability# - dollar amount

Patient Liability* - dollar amount

**Payment Plans#**

Facility ID* - Medicare, Medicaid, NPI, etc.

- ID for facility professional provided services in, if multiple use hospital ID

Medical Record Number (MRN)* - varchar

- This column will flag red if there is a medical record number that does not appear in the Patient Demographics* sheet. Please try to ensure that each patient shows up on both sheets

Encounter Number - varchar

Date of Service - date

- For inpatient stays, can either use admission or discharge date

Date Payment Plan Established - date

Total amount of Payment Plan* - dollar amount

Date Payment Plan Completed - date

- Should be blank for any payment plans still running

Amount written off at end of Payment Plan* - dollar amount

**Collections#**

Facility ID* - Medicare, Medicaid, NPI, etc.

- ID for facility professional provided services in, if multiple use hospital ID

Medical Record Number (MRN)* - varchar

- This column will flag red if there is a medical record number that does not appear in the Patient Demographics* sheet. Please try to ensure that each patient shows up on both sheets

Encounter Number - varchar

Date of Service - date

Date Patient was notified of any collection actions - date

Date Sent to Collections - date

Collection Agency Debt Sold To - varchar

Facility or Physician Name* - varchar

Health Care Professional In or Out of Network - varchar

- Only needs to be specified for Physicians

Hospital Discounted Care Allowed Amount - dollar amount

Third Party Name - varchar

Amount of Third-Party Payment# - dollar amount

Date of Third-Party Payment - date

Third Party Copay Amount - dollar amount

Third Party Deductible Amount - dollar amount

Total Amount of Patient Payments – dollar amount

Amount of Account sent to Collections* - dollar amount