Subject: **Billing and Collections Policy and Procedures**

Policy #	**0004**	**Implemented:**	
Reference(s):	Free Bed Funds Policy; Financial Assistance Program Policy	**Revisions:**	10/25/12, 11/08/13, 11/12/13, 10/06/14,10/05/15, 10/11/16
Approval:	EM	**Reviewed**	
Department:	Patient Business Services	**Page:**	1 of 2

Revised in accordance with the IRS and Treasury 501(r) final rule under the authority of the Affordable Care Act and the Fair Debt Collection Practices Act.

Purpose

This policy establishes reasonable procedures regarding collection of patient accounts, including Extraordinary Collection Actions (ECAs) that may be taken by Stamford Hospital or contracted external collection agencies and law firms.

Policy

It is the policy of Stamford Hospital to pursue collection of patient balances from patients who have the ability to pay for services. Stamford Hospital will make reasonable efforts to identify patients who may be eligible for financial assistance. Collection procedures will be applied consistently and fairly for all patients regardless of insurance status. All collection procedures will comply with applicable laws. In accordance with the Stamford Hospital Financial Assistance Program, hospital patients will be notified of and given the opportunity to seek a partial or complete reduction of their hospital bill for covered medical services.

The Stamford Hospital Financial Assistance Policy, the Financial Assistance Plain Language Summary and the Financial Assistance Application are available on the Stamford Health website here: http://www.stamfordhealth.org/fap

Summary: *Stamford Hospital's Patient Business Services Department must take certain steps to notify a patient of his/her opportunity to submit a Financial Assistance Program application. The hospital will not engage any ECAs for at least 120 days after the patient receives the initial bill for hospital services. After this initial 120-day period has passed, and for the next 120 days, the hospital must suspend any ECA against an individual if he/she submits an application for financial assistance.*

- The Hospital provides the first billing statement following services. For balances after insurance, the Hospital provides a second statement 30 days after the initial statement. All statements contain information regarding the availability of the FAP including contact information.

- During the final phase of the dunning cycle, the Hospital will notify, in writing, patients of the following:
    - The ECA(s) the hospital facility/authorized party may take to obtain payment for care;
    - State a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date that the written notice is provided.
    - Provide a Financial Assistance Plain Language Summary.

- The Hospital will make reasonable efforts to verbally notify the individual about the FAP and assistance available to the individual.

- Hospital must suspend any ECA against an individual if he/she submits a FAP application.
    - Individuals must be given a reasonable period of time to respond to written requests for additional information.

- In the event that a patient has made payment(s) to the Hospital for services provided to the patient, then subsequently the Hospital determines that the patient is FAP-eligible, Hospital will provide a refund for the amount a patient has paid for care that exceeds the amount the patient is determined to be personally responsible for paying under the FAP, unless such excess amount is less than $5.00.

- Both Medicare and non-Medicare accounts are to be returned to the hospital from the external collection agencies, identified as uncollectible to be written off to bad debt uncollectible after a period of (1) year when the agencies have not been able to contact the patient, the patient has not responded or the patient is deemed judgment proof.

Legal Actions

- Patient accounts are reviewed and approved by the Director and or Manager of PBS for direct referral to the collection attorneys.

- Accounts are directly referred to attorneys in cases where we have identified circumstances where legal proceedings will be eminent and the routine collection agency time frames or procedures would not be effective.

- Stamford Hospital will, when appropriate, engage in the following ECA's
    (i) Commencing any legal action to collect a bill from a patient (but this does not include filing of a claim in a pending bankruptcy proceeding)
    (ii) reporting to a credit reporting agency or credit bureau
    (iii) placing a lien on the individual's property (except liens permitted under state law upon judgments or settlements for personal injury related to the care provided)
    (iv) attaching or seizing any individual bank account or other personal property
    (v) Garnishing wages.

- The hospital will not engage in the following ECA's
    (i) Foreclosing on real property
    (ii) Causing and individual to be subject to a writ of body attachment or otherwise causing an individual's arrest
    (iii)Selling an individual's debt to another party unless certain conditions are met
    (iv)Deferring or denying medically necessary care or requiring payment before providing care because of non-payment of a prior bill.

**Filing a bankruptcy claim is not considered to be an ECA.*

The Stamford Hospital

Subject:	Stamford Hospital Financial Assistance Prenatal Program (FAPPNP)		
Policy #	0015	**Implemented:**	10/01/08
Reference(s):		**Revisions:**	06/05/12, 11/27/2013
Approval:	EM, CR	**Reviewed**	10/01/09
Department:	Patient Business Services	**Page:**	1 of 2

Purpose

Stamford Hospital Financial Assistance Prenatal Program Policy.

Effective date 10/01/2008

Policy

I. Stamford Hospital is committed to provide financial assistance to patients seeking prenatal care utilizing a fixed fee payment program. Service provided beyond this program will be processed through the Hospital Financial Assistance Program.

II. Procedure

1. Women who present themselves for prenatal care and a determined to be eligible for financial assistance will be offered the prenatal program. This program does not provide coverage for the delivery or newborn care.

2. Eligibility for financial assistance is based upon financial need.
    a. Stamford Hospital will use a sliding scale based on multiples of the Federal Poverty Guidelines to determine the percent of financial assistance granted.
    b. Stamford Hospital will consider available assets. Available assets do not include the patient's primary residence or automobiles needed for regular transportation.

3. Patients are asked to provide supporting documentation to authorize representatives to assist them in determining eligibility for Financial Assistance Programs Prenatal (FAPPN).

4. Applications must be initially approved by one of the following authorized employees: Optimus Financial Counselors, Stamford Hospital Financial Assistance Counselors, Stamford Hospital Patient Assistance Coordinator and designated Management personnel within The Patient Business Services Department.

5. If approved, the fixed fee cost of the program will be applicable during the months of prenatal care proceeding delivery. Payment plans should be established at the initial visit and patients will be asked to make payments at each visit. If a patient fails to comply with their payment agreement or schedule, the patient may be billed for the full charges of care provided. If the patient is truly unable to pay, the patient must request an additional review for financial assistance on the remaining balances.

6. Retroactive adjustments to patient bills may be applicable based on their current ability to pay.

To apply for financial assistance, an application for this program should be completed and submitted to the Patient Business Services office together with supporting documents. Applications for financial assistance programs (FAP) are provided to patients by the Public Assistance Coordinator, Financial Counselors, Social Workers, Patient Access Representative and Customer Service Representatives. Social Services, Case Management and other hospital departments refer patients to the Public Assistance Coordinator or the Financial Counselors for screenings. The application and supporting documents are generally required to determine eligibility for financial assistance, and will be considered at any time.

Stamford Hospital

Subject:	Stamford Hospital Financial Assistance Program

Policy #	**0016**	**Implemented:**	10/01/08
Reference(s):		**Revisions:**	06/05/12,11/27/2013
Approval:	EM, CR	**Reviewed**	
Department:	Patient Business Services	**Page:**	1 of 2

Purpose

Stamford Hospital Financial Assistance Program Policy

Effective Date: October 1, 2008

Stamford Hospital Financial Assistance Program Policy

I. POLICY:

Stamford Hospital's stated mission is to provide a broad range of high quality health and wellness services focused on the needs of our communities. Stamford Hospital is committed to providing financial assistance to persons who have healthcare needs and are uninsured, under insured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation.

II. PROCEDURE:

1. The following services are eligible for inclusion under this policy:
   a. Emergency medical services provided in an emergency room setting;
   b. Services for a condition which, if not properly treated, would lead to an adverse change in the health status of an individual;
   c. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting;
   d. Medically necessary services, evaluated on a case by case basis at Stamford Hospital's discretion

2. Eligibility for financial assistance is based upon financial need.
   a. Stamford Hospital will use a sliding scale based on multiples of the federal poverty guidelines to determine the percent of financial assistance granted.
   b. Stamford Hospital will consider available assets. Available assets do not include the patient's primary residence or automobiles needed for regular transportation.

3. There are instances when a patient may appear eligible for financial assistance but there is no application on file due to a lack of supporting documentation. Under these circumstances financial assistance may be granted. These situations include but are not limited to:
   a. Homeless individuals with a Shelter address or unknown address where there is no means of contact after service rendered.
   b. Deceased patients where it has been determined that there is no open estate or that the estate is insolvent;
   c. Other situations on a case by case basis at Stamford Hospital's discretion

4. Retroactive adjustments to patient bills may be applicable based on their current ability to pay.

5. Applications must be initially approved by one of the authorized employees of Stamford Hospital. Authorized employees are the Patient Assistance Coordinator, Financial Assistance Counselors, and designated management personnel within the Patient Business Services Department.

To apply for financial assistance, an application for this program should be completed and submitted to the Patient Business Services office together with supporting documents. Applications for financial assistance programs (FAP) are provided to patients by the Public Assistance Coordinator, Financial Counselors, Social Workers, Patient Access Representative and Customer Service Representatives. Social Services, Case Management and other hospital departments refer patients to the Public Assistance Coordinator or the Financial Counselors for screenings. The application and supporting documents are generally required to determine eligibility for financial assistance, and will be considered at any time.

Subject:	**Hospital Bed Funds Policy and Procedures**

Policy #	**018**	**Implemented:**	05/31/07
Reference(s):		**Revisions:**	09/15/10
Approval:	EM	**Reviewed:**	02/18/2014
Department:	Patient Business Services	**Page:**	1 of 4

Purpose

This policy and procedure rescinds all other policies and procedures and memoranda relating to this subject issued prior to November 2004. Stamford Hospital and pertinent outpatient treatment centers and clinics are referred to collectively in this policy as the Hospital.

To outline the Hospital's policy and procedures for providing access to hospital bed funds for eligible patients in a manner consistent with the intent of the donors of such funds and the Hospital's mission to provide medical care in a compassionate and caring manner.

DEFINITIONS

"Hospital Bed Funds" or "Funds" means any gift of money, stock, bonds, financial instruments or other property made by any donor for the purpose of establishing a fund to provide medical care, including, but not limited to, inpatient or outpatient care, to eligible patients of the Hospital, being patients who have financial need.

"Eligible Patients" means those patients designated as eligible recipients in the gift instrument or other documentation establishing the Fund or, to the extent such designation is not made or is no longer applicable for any reason, patients who demonstrate financial need as determined by the Hospital following examination of available income, assets and such other information as may be required.

"Collection Agent" means any person, either employed or under contract to the Hospital who is engaged in the business of collecting payment from consumers for medical services provided by the Hospital, and includes, but is not limited to, attorneys performing debt collection activities.

Policy

OBJECTIVE OF POLICY

To administer Hospital Bed Funds effectively and efficiently, and ensure the Hospital is in compliance with Conn. Gen. Stat. §19a-509b, as amended by Public Act 03-266.

STATEMENT OF POLICY

It is the policy of the Hospital to provide its patients with the opportunity to apply for Hospital Bed Funds that may be available from time to time and to grant such Funds to Eligible Patients in order to help reduce or eliminate the cost of their medical care. Distribution of Hospital Bed Funds shall be made in accordance with the instructions of the fund donors and, to the extent such instructions are not provided or not applicable for any reason, in accordance with the procedures set forth below.

PROCEDURES

1. The Hospital shall at all times cause to be posted the public notice ("Notice") attached hereto at Exhibit A regarding the availability of Hospital Bed Funds. The Notice shall be posted in English and Spanish in conspicuous places in each patient admitting location of the Hospital including, but not limited to, the admissions offices, emergency room, social services department and patient accounts/billing offices.

2. The Hospital shall also make available the one page summary ("Summary") attached hereto at Exhibit B describing Hospital Bed Funds and how to apply for them. The Summary shall be available in various locations throughout the Hospital, including, but not limited to, the admissions offices, emergency room, social services department and patient accounts/billing offices. The Summary shall also be available from any Collection Agent and provided directly to patients if during the admission process or during the review of the financial resources of the patient, patient registration personnel, financial counselors or other employees of the Hospital believe the patient will have limited funds to pay for any portion of the patient's hospitalization not covered by insurance. In addition, the Summary shall be included in all bills and collection notices sent by Collection Agents.

3. The Hospital will provide training to all relevant staff, including, but not limited to, its financial counselors, social workers, discharge planners and billing personnel concerning the existence of Hospital Bed Funds, eligibility requirements and the procedures for application. This training program shall be overseen by the Patient Access Business Services Department.

4. Patients applying for Hospital Bed Funds shall be furnished with the application form ("Application") attached hereto at Exhibit C. Financial counselors in the Patient Registration Department shall assist Hospital inpatients with the Application process while financial counselors assigned to the Hospital's ambulatory clinics and Customer Service Department shall perform the same function for outpatients and/or post-discharge patients seeking to apply. All patients, including, but not limited to, Medicare and Medicaid beneficiaries seeking relief from cost-sharing amounts, shall be permitted to apply for Hospital Bed Funds at any time during or after their hospital stay or outpatient visit.

5. The Hospital's Finance Department, working in collaboration with the Stamford Health Foundation ("SHF"), shall keep a listing of all Hospital Bed Funds that are available to Eligible Patients. This listing shall contain the names of all Funds, an internally assigned account number and set forth all relevant eligibility criteria and restrictions concerning use of the Funds. The listing shall be updated periodically to reflect available Funds and current Fund balances, and be distributed to the following personnel: Chief Financial Officer, Senior Vice President of SHF, Executive Director of Finance, Executive Director of Patient Access Business Services, Manager of Patient Access Business Services, Director of Clinical Compliance, Public Assistance Coordinator and all financial counselors involved in the Application process.

5. The Hospital's Finance Department, working in collaboration with the Stamford Health Foundation ("SHF"), shall keep a listing of all Hospital Bed Funds that are available to Eligible Patients. This listing shall contain the names of all Funds, an internally assigned account number and set forth all relevant eligibility criteria and restrictions concerning use of the Funds. The listing shall be updated periodically to reflect available Funds and current Fund balances, and be distributed to the following personnel: Chief Financial Officer, Senior Vice President of SHF, Executive Director of Finance, Executive Director of Patient Access Business Services, Manager of Patient Access Business Services, Director of Clinical Compliance, Public Assistance Coordinator and all financial counselors involved in the Application process.

6. The documentation and verification requirements for determining whether an applicant will be deemed an Eligible Patient for purposes of receiving any Hospital Bed Funds that may be available shall be based on the criteria established by the Fund donor or, to the extent such criteria is not provided or not applicable for any reason, by the applicant providing the information required under the Hospital's Financial Assistance Program ("FAP") to demonstrate financial need. Once the applicant is deemed an Eligible Patient, the Patient Access Business Services Department shall determine the amount to be granted from any available Hospital Bed Funds based on the parameters established by the Funds or, if none exist, the particular facts and circumstances of the case. Stamford Hospital may have potential applicants referred to them from the Optimus Clinics, Stamford Hospital Sub-specialty Clinics, Social Services Department Patient Assistance Co-ordinator, Financial Counselors and Customer Service Staff.
A check request should be completed prior to final approval. The payment(s) to be applied from the appropriate bed fund(s) to qualifying accounts will be calculated using the latest available published acute care hospital ratios of costs to charges. The difference will be adjusted to an Administrative Free Bed Fund write off code.

7. In distributing Hospital Bed Funds, the Director of Revenue Cycle shall have authority to grant amounts up to $5,000. Awards that exceed $5,000 but are less than $25,000 shall require the approval of the Executive Director of Reimbursement & Revenue Cycle while awards of $25,000 and above shall require the approval of the Chief Financial Officer. The amounts awarded shall be applied against the Eligible Patient's outstanding bill and shall not be paid directly to any individual.

Grants provided to Stamford Hospital include the Patient Care Fund, M. Dolittle Income and William Pitt FMC Funds.

8. Unless specified otherwise in the gift instrument or other documentation establishing the Funds, the Hospital shall only grant Hospital Bed Funds to cover medically necessary inpatient or outpatient services provided to residents of Stamford, Darien and New Canaan, Connecticut. The Hospital's Patient Access Business Services Department shall apply the same standards as used under the FAP for purposes of determining medical necessity.

9. Applicants for Hospital Bed Funds shall be notified in writing of any award or rejection and the reason for such rejection within fifteen (15) days of submitting an Application and all income or other verification information that is required.

10. The Hospital shall not refer a patient's account to any Collection Agent or initiate an action against the patient or the patient's estate to collect fees arising from the care provided at the Hospital unless it has made a determination whether the individual is an uninsured patient, as defined in Con. Gen. Stat. §19a-673, and is not eligible for Hospital Bed Funds. If at any point in the debt collection process, the Hospital or any of its agents or employees becomes aware that the debtor is eligible for Hospital Bed Funds, free or reduced price hospital services, or any other program that would result in the reduction or elimination of the debt due the Hospital, collection efforts shall be promptly discontinued and the collection file shall be referred to the Patient Access Business Services Department for a determination of such eligibility. Collection efforts shall not resume until the eligibility determination is made.

11. The Patient Access Business Services Department in conjunction with the Executive Director of Finance shall maintain and annually compile, at the end of each fiscal year, the following information: (1) the number of applications for Hospital Bed Funds; (2) the number of patients receiving Hospital Bed Fund grants and the actual dollar amounts provided to each patient from such Funds; (3) the fair market value of the principal of each individual Hospital Bed Fund, or the principal attributable to each Fund if held in a pooled investment; (4) the total earnings for each Hospital Bed Fund or the earnings attributable to each Fund; (5) the dollar amount of earnings reinvested as principal in Hospital Bed Funds, if any; and (6) the dollar amount of earnings available from Hospital Bed Funds available for patient care. This information shall be permanently retained by the Patient Access Business Services Department and made available to the Office of Health Care Access upon request.

Reconciliation to Patient's Account:
Once the check request has been granted and the check is cut, Cash Applications will post the payment, using the Meditech Procedure Code PSPFB. The remaining balance is then to be adjusted off using procedure code AADMINFBF.

STAMFORD HOSPITAL
The Regional Center for Health

STAMFORD HOSPITAL
30 SHELBURNE RD
PO BOX 9317
STAMFORD, CT 06904-9317
(800) 440-5238

www.StamfordHospital.org

ARE YOU UNINSURED?

If you meet the definition "uninsured" as defined by Section 19a-673 of the Connecticut General Statutes, you may be eligible for Hospital, "bed funds" or Financial Assistance. You are "uninsured" if you meet all of the following:

You have one or more outstanding balances due to Stamford Hospital.

You have applied and been denied for any medical or health care coverage provided under Medicaid or Limited Income Adults (LIA). Proof of denial is required.

You are not eligible for coverage for hospital services under any other health or accident insurance program (including workers' compensation, third party liability, or motor vehicle insurance).

Your household income is at or below 250% of the Federal Poverty Guidelines. Proof of income is required.

To find out if you qualify, please contact us. We are also available to assist you with the Medicaid/LIA application process and other Stamford Hospital Financial Assistance Programs. Please contact us at the following location.

Stamford Hospital, Customer Service Department,
1351 Washington Blvd. 7th Floor, Stamford, CT 06904-9317
Telephone: 203-276-7572, 9:00am - 5:00pm, Monday-Friday

2015 FEDERAL POVERTY GUIDELINES	
FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Size of family unit	Poverty Guidelines
1	$11,770.00
2	$15,930.00
3	$20,090.00
4	$24,250.00
5	$28,410.00
6	$32,570.00
7	$36,730.00
8	$40,890.00
For family units more than 8 members, add $4,160 for each additional member. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)	

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¿NO TIENE SEGURO MEDICO?

Si usted satisface la definición de "no asegurado" seqún consta en la sección 19a-673 de los estatutos generales del estado de Connecticut, usted puede ser eligible para obtener asistencia. Financiera o fondos de cama si cumple con los siguientes requisitos:

- ☐ Usted tiene uno o mas saldos pendientes de pago con el Hospital de Stamford.
- ☐ Usted ha solicitado cualquier cobertura de seguro medico o de cuidado de la salud suministrada por Medicaid o ("LIA") ha sido rechazado por no satisfacer los requisitos de ingresos u otros.
  - Se require prueba del rechazo.
- ☐ No tiene derecho a ningún seguro que cubra los servicios de hospitales debajo de ningún otro programa de seguro de salud o de accidentes (esto incluye la compensación de obreros, seguro de automóvil o responsabilidad de terceros.)
- ☐ El ingreso de su familia equivale al 250% de las Directrices Federales de Ingreso de Pobreza, o menos.
  - Se require prueba de ingresos.

Llámenos para saber si usted llena los requisitos. También le podremos ayudar con el proceso de solicitud de Medicaid y LIA. Puede Communicarse con nosotros en una de las siguiente oficinas.

Stamford Hospital, Departamento del, Servicio al Cliente,
1351 Washington Blvd. 7th Floor, Stamford, CT 06904-9317
Teléfono: 203-276-7572, 9:00 a.m. - 5:00 p.m., Lunes a Viernes

2015 GUÍA FEDERAL DE POBREZA	
PARA LOS 48 ESTADOS CONTINGUOS Y EL DISTRITO DE COLUMBIA	
Tamaño de la unidad familiar	Guías de pobreza
1	$11,770.00
2	$15,930.00
3	$20,090.00
4	$24,250.00
5	$28,410.00
6	$32,570.00
7	$36,730.00
8	$40,890.00
Para las unidades familiares de más de 8 miembros, agregue $ 4,160 por cada miembro adicional. (El mismo incremento se aplica a los tamaños más pequeños de la familia también, como puede verse en las figuras anteriores.)	

STAMFORD HEALTH

One Hospital Plaza
PO Box 9317
Stamford, CT 06904-9317
(855) 748-0682

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ARE YOU UNINSURED?

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- ☐ You have one or more outstanding balances due to Stamford Hospital.
- ☐ You have applied and been denied for any medical or health care coverage provided under Medicaid or Limited Income Adults (LIA). Proof of denial is required.
- ☐ You are not eligible for coverage for hospital services under any other health or accident insurance program (including workers' compensation, third party liability, or motor vehicle insurance).
- ☐ Your household income is at or below 250% of the Federal Poverty Guidelines. Proof of income is required.

To find out if you qualify, please contact us. We are also available to assist you with the Medicaid/LIA application process and other Stamford Hospital Financial Assistance Programs. Please contact us at the following location.

Stamford Hospital, Customer Service Department,
1351 Washington Blvd. 7th Floor, Stamford, CT 06904-9317
Telephone: (855) 748-0682, 9:00am - 5:00pm, Monday - Friday

2016 FEDERAL POVERTY GUIDELINES	
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For family units more than 8 members, add $4,160 for each additional member. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)	

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- ☐ Usted tiene uno o mas saldos pendientes de pago con el Hospital de Stamford.
- ☐ Usted ha solicitado cualquier cobertura de seguro medico o de cuidado de la salud suministrada por Medicaid o ("LIA") ha sido rechazado por no satisfacer los requisitos de ingresos u otros.
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For family units more than 8 members, add $4,160 for each additional member. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)	

Public Notice

Hospital bed funds may be available to help pay for your care.

Stamford Hospital also offers other financial assistance programs based on ability to pay.

To apply, please contact the Customer Service Department at 203-276-7572.

Aviso Al Publico

Fondos para cama del hospital le podrian ayudar con su tratamiento.

El hospital de Stamford tambien ofrece otras ayudas financieras basada en su abilidad de pago.

Para solicitar, por favor contactar al departamento de servicios al clientes.
203-276-7572.

STAMFORD HOSPITAL | The Regional Center for Health

Affiliate Columbia University-College of Physicians & Surgeons
Member New York-Presbyterian Healthcare System
A Planetree Hospital

30 Shelburne Road
P.O. Box 9317
Stamford, CT 06904-9317
203.276.1000
www.stamhealth.org

PATIENT NOTICE ON FINANCIAL ASSISTANCE

Stamford Hospital is proud of its not-for-profit mission to provide quality health care to the communities it serves. If you are coping with a personal financial hardship, and are facing significant debts owed to the Hospital, "bed funds" may be available to cover the cost (partially or fully) for inpatient, outpatient and emergency services rendered at the hospital for qualifying patients.

You may request to have your case presented to the Patient Access and Business Services Department to determine whether you are eligible for bed funds to the extent they are available. The Patient Access and Business Services Department has the authority to grant bed funds based on financial and personal need. [In most cases, eligibility for such funds will be based on the patient demonstrating an income level at or below two hundred and fifty (250%) of the federal poverty guidelines.]

You can obtain further information on available bed funds and an application by calling (203) 276-7008 or writing to the following address:

Patient Access and Business Services Dept.
Stamford Hospital
P.O. Box 9317
Stamford, CT 09604-9317
Attention: Public Assistance Coordinator

You will receive written notice of the outcome of your case, including reason(s) if your case is rejected. You may reapply for bed funds at any time and are encouraged to do so if your financial situation significantly worsens after the time that your initial application is rejected. Additional bed funds may also become available on an annual basis.

Other assistance options, such as a sliding scale discount available through The Stamford Hospital's Financial Assistance Program and a fixed fee pre-natal program, may also apply to your situation. The Stamford Hospital's financial counselor will inform you of these programs and other available options to assist you with your outstanding balance.

Additional support also may be available to you under various federal and state programs, including Medicare, Medicaid and state administered general assistance ("SAGA"). For more information about these programs, you can contact the hospital's Public Assistance Coordinator or your town's social service or local health department. With your written permission, your town representative can assist you with our application processes, as well as determine if you qualify for any other assistance programs such as the HUSKY program for uninsured children, the CONNPACE prescription drug program for seniors and Food Stamps.

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The Regional Center for Health

MR#_____ ☐ FAP ☐ Pre-natal FAP

Financial Assistance Application
Complete all applicable items

Date of Request: ___/___/____

Patient information:
Last name: _____ First Name _____ Middle Initial ___

Date of Birth: ____/____/____ Social Security Number: _____-____-_____

Address: _____ Apt # _____

City: _____ State: _____ Zip code: _____

Home Telephone# (___)_____ Work Telephone# (___)_____

Employer: _____

Employer's address: _____

Person Responsible for the bill: _____

Social Security Number: _____-_____-_____

Employer of person responsible for the bill: _____

Employer's telephone # (____)_____

Employer's address: _____

Dependents in household:

	Name	Age	Date of Birth	Relationship to Patient
1)				
2)				
3)				
4)				
5)				

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Please provide copies of available documents on the attached list of Documentation and Verification Forms. Patients are to provide this information within 15 days of receiving the application. All information provided, discussed or recorded in relation to this application is confidential. If you have questions or require further assistance contact a Financial Assistance Counselor at (203) 276-7515 or (203) 276-4831 at the Patient Business Department.

Additional information that the applicant wishes to be taken into consideration:

_____

_____

_____

I hereby request financial assistance from Stamford Hospital, including access to hospital bed funds that may be available and for which I may be eligible. I understand that the information which I have submitted is subjected to verification by Stamford Hospital. I certify that the above information is true and correct. I understand that I may be asked to apply for public assistance, if eligible.

Applicant's Signature: _____ Date: _____

Please note that failure to complete this application and provide the information requested within the time allotted will delay processing of your request and may result in a determination that you are not eligible for financial assistance.

FOR HOSPITAL USE ONLY

Bed Fund Approved: _____ Account #: V_____ Denied: _____

Reason for Denial: _____

Financial Assistance Approved: _____@_____% Denied: _____

Reason for Denial: _____ Date: _____

By: _____ Date: _____

Amount of Adjustments: $_____ Code: _____

Completed by: _____ Date: _____

Form Taken By: _____

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Documentation and Verification Forms

Please provide applicable documents listed below for applicant/spouse or significant other and children (if applicant is a minor provide parents information) to your Financial Assistance Counselor or the Patient Business Services Department.

PLEASE PROVIDE US WITH COPIES OF THE FOLLOWING DOCUMENTATION

Insurance:

Health ☐ YES or ☐ NO Liability ☐ YES or ☐ NO

Workers comp ☐ YES or ☐ NO MVA ☐ YES or ☐ NO

Federal and State Benefits:

- ☐ Department of Social Services Denial Letter
- ☐ Food Stamps/Cash Assistance Letter
- ☐ Department of Social Services Medical (Medicaid) coverage
- ☐ Social Security Benefits Letter

Identification:

- ☐ Photo ID / Passport / Permanent Resident Card
- ☐ Proof of Address (utility bills, cable, telephone)
- ☐ Children's Birth Certificate

Income:

- ☐ Most Recent Tax Return and W-2 or 1099
- ☐ Pay Stubs for last month (4 weekly / 2 bi-weekly)
- ☐ Notarized letter from employer or self
- ☐ Unemployment payment History
- ☐ If unemployed please provide a notarized letter indicating how you support yourself.
- ☐ Alimony and Child Support

Assets:

- ☐ Most recent Bank Account Statement (Checkings, Savings, CD's, 401K, 403B)
  - ☐ YES or ☐ NO if no, please initial _____
- ☐ Do you own Property other than the primary residence?
  - ☐ YES or ☐ NO if yes, rental income $_____

Residence Information:

- ☐ Rent Receipt / Mortgage Statement
- ☐ Notarized letter from landlord or self
- ☐ Shelter letter

Pre-natal:

- ☐ Pre-natal contract (Optimus/TSH contract)

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MR#_____ ☐ FAP ☐ Pre-natal FAP

Solicitud de Asistencia Financiera
Complete todo lo que le aplique

Fecha: ____/_____/_____

Información del Paciente:
Apellido: _____ Primer Nombre:_____

Fecha de nacimiento: ____/___/_____ Numero de Seguro Social: ____-_____-____

Dirección: _____ # de Apt: _____

Ciudad: _____ Estado:_____ Código Postal: _____

Teléfono de la casa: (____)_____ Teléfono del empleo: (___)_____

Empleo: _____

Dirección del Empleo: _____

Persona responsable de la(s) factura(s): _____

Numero de Seguro Social: _____-_____-_____

Empleo de la persona responsable: _____

Teléfono del empleo: (____)_____

Dirección del empleo: _____

Personas a su cargo:

	Nombre	Edad	Fecha de Nacimiento	Relacion al Paciente
1)				
2)				
3)				
4)				
5)				

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Favor de proveer copias de los documentos disponible en la lista de documentos. Favor de traer los documentos antes de 15 días del día que se le fue dado el formulario. Toda la información sometida por escrito, verbal o gravada en relación con el formulario es confidencial. Si tiene preguntas o necesita mas información por favor llamar a un Consejero(a) Financiero(a) al numero (203) 276-7515 o (203) 276-4831 en el Departamento de Servicios al Paciente.

Información adicional que el aspirante quiera que sea tomado en consideración:

_____

_____

_____

Por este medio pido ayuda Financiera al Hospital de Stamford, inclusive acceso a fondos de cama de Hospital que pueden estar disponibles. Yo comprendo que la información que he sometido esta sujeta a verificación por el Hospital de Stamford. Certifico que la información dada es la correcta y verdadera. Entiendo que me pueden pedir que aplique para asistencia publica, si fuera elegible.

Firma del Aspirante: _____ Fecha: ____/____/_____

Sin la información dada o no dar prueba para procesar el formulario en el tiempo indicado podría resultar en negación de la ayuda financiera o no ser elegible para el programa.

USO DEL HOSPITAL DE STAMFORD

Fondos para cama del Hospital: _____ Cuenta: V_____ Negada _____

Razón para ser negada: _____

Asistencia Financiera Aprovada: _____@_____ %Negada _____

Razón por ser negada: _____ Fecha_____

Procesador: _____ Fecha_____

Suma ajustada: $_____ Codigo: _____

Prosesador:_____ Fecha:_____

Formulario recibido por:_____

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LISTA DE DOCUMENTOS

Favor de proveer fotocopias de los documentos disponible del paciente/esposo(a) o pareja y niños(a) (si el paciente es menor de edad proporcionar la información de los padres) a su Consejero(a) de Asistencia Financiera o al Departamento de Servicios al Paciente.

Seguro:

Medico	☐ SI o ☐ NO	Liability	☐ SI o ☐ NO
Compensación de Trabajo	☐ SI o ☐ NO	Auto	☐ SI o ☐ NO

Beneficios Federales y Estatales:

☐ Copia de la carta en la cual el departamento de Servicio Sociales indica que no es elegible.

☐ Prueba de assistencia del Gobierno como cupones de alimentos y/o dinero en efectivo.

☐ Seguro de salud del Departamento de Servicio Sociales

☐ Beneficios de Seguro Social

Identification:

☐ Identificación con foto / Pasaporte / Tarjeta de Residencia

☐ Prueba de domicilio (utilidades, teléfono, cable)

☐ Certificado de nacimiento de los niños

Ingresos:

☐ Copia de la ultima planilla de impuestos (taxes) o formularios W2 / 1099

☐ Copia de los talonarios mas recientes de cheque del ultimo mes

☐ Carta Notarizada de su empleo

☐ Historial de pagos de desempleo

☐ Si no trabaja una carta notarizada indicando como se mantiene

☐ Carta de Manutencion de hijos

Finanzas e Inversiones:

☐ Información de cuenta de banco (cuenta de cheques, cuenta de ahorros, 401K/403B)

☐ SI o ☐ No por favor de poner sus iniciales si no tiene cuenta de banco _____

☐ Es dueno de otra propiedad que no sea su propiedad princinpal?

☐ SI o ☐ No

Usted la usa para Ingreso? ☐ SI o ☐ No

Cuanto recibe mensual $_____

Informacion Residencial:

☐ Recibo de renta / Hipoteca

☐ Carta notarizada de su propietario

☐ Alberge / Refugio

Pre-natal:

☐ Contrato Pre-natal (Optimus/TSH)

TSH FINANCIAL ASSISTANCE CALCULATION TABLE

Based on Federal Poverty Guidelines Effective 02/2015

	A	B	C	D	E	F	G
			FAP -Level 0 100%	FAP -Level 1 90%	FAP -Level 2 80%	FAP -Level 3 70%	FAP -Level 4 60%
	Family Unit Size	FEDERAL Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)
Income Per Year	1	$11,770	$23,540	$29,425	$35,310	$41,195	$47,080
Income Per Year	2	$15,930	$31,860	$39,825	$47,790	$55,755	$63,720
Income Per Year	3	$20,090	$40,180	$50,225	$60,270	$70,315	$80,360
Income Per Year	4	$24,250	$48,500	$60,625	$72,750	$84,875	$97,000
Income Per Year	5	$28,410	$56,820	$71,025	$85,230	$99,435	$113,640
Income Per Year	6	$32,570	$65,140	$81,425	$97,710	$113,995	$130,280
Income Per Year	7	$36,730	$73,460	$91,825	$110,190	$128,555	$146,920
Income Per Year	8	$40,890	$81,780	$102,225	$122,670	$143,115	$163,560
	Each addtl.: Add	$4,160					

			FAP -Level 0 100%	FAP -Level 1 90%	FAP -Level 2 80%	FAP -Level 3 70%	FAP -Level 4 60%
	Family Unit Size	FEDERAL Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)
Income Per Month	1	$981	$1,962	$2,452	$2,943	$3,433	$3,923
Income Per Month	2	$1,328	$2,655	$3,319	$3,983	$4,646	$5,310
Income Per Month	3	$1,674	$3,348	$4,185	$5,023	$5,860	$6,697
Income Per Month	4	$2,021	$4,042	$5,052	$6,063	$7,073	$8,083
Income Per Month	5	$2,368	$4,735	$5,919	$7,103	$8,286	$9,470
Income Per Month	6	$2,714	$5,428	$6,785	$8,143	$9,500	$10,857
Income Per Month	7	$3,061	$6,122	$7,652	$9,183	$10,713	$12,243
Income Per Month	8	$3,408	$6,815	$8,519	$10,223	$11,926	$13,630
	Each addtl.: Add	$346.67					

			FAP -Level 0 100%	FAP -Level 1 90%	FAP -Level 2 80%	FAP -Level 3 70%	FAP -Level 4 60%
	Family Unit Size	FEDERAL Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)
Income Per Week	1	$226	$453	$566	$679	$792	$905
Income Per Week	2	$306	$613	$766	$919	$1,072	$1,225
Income Per Week	3	$386	$773	$966	$1,159	$1,352	$1,545
Income Per Week	4	$466	$933	$1,166	$1,399	$1,632	$1,865
Income Per Week	5	$546	$1,093	$1,366	$1,639	$1,912	$2,185
Income Per Week	6	$626	$1,253	$1,566	$1,879	$2,192	$2,505
Income Per Week	7	$706	$1,413	$1,766	$2,119	$2,472	$2,825
Income Per Week	8	$786	$1,573	$1,966	$2,359	$2,752	$3,145
	Each addtl.: Add	$80.00					

This chart indicates the criteria for income used to determine if patients are eligible for financial assistance at Stamford Hospital. For each family size unit in Column A, income levels are listed that determine free service based either on yearly, monthly , or weekly incomes. Column B indicates the Federal poverty guidelines, while Columns C through G indicates based on the patients family income, the appropriate level for the Financial Assistance Program [See Below] These income levels are in direct relationship to the federal poverty guidelines which are determined by the US Govt on a yearly basis. The number in the (X_) indicates the multiplier applied to Column B to determine the Stamford Hospital Guidelines.

Level 0 100% adjustment to patient's account balance*

* Self pay patients are asked to pay what they can afford prior to or at the time of service. Amounts collected prior to, or at the time of service are not refundable.

Level 1 90% adjustment to patient's account balance. Patient is responsible for paying 10% of the remaining balance

Level 2 80% adjustment to patient's account balance. patient is responsible for paying 20% of the remaining balance

Level 3 70% adjustment of patient's account balance. patient is responsible for paying 30% of the remaining balance

Level 4 60% adjustment of patient's account balance. patient is responsible for paying 40% of the remaining balance

Income

Financial Assistance (FAP) applications may be accepted and considered for inpatient and outpatient services.
Applications for financial assistance will require verifiable proof of income and/or assets (i.e., W-2 forms, tax return, payroll check stubs, statements from employer, bank records, tax records, self employment disclosure, etc.
All other avenues to obtain financial assistance and third party payment must be exhausted prior to receiving financial assistance.
A determination may require screening for a Qualified Health Plan (QHP) or Husky eligibility through Access Health CT or other States' programs.

Assets

The applicant's primary residence and primary vehicle will be exempt from inclusion of assets.
Any additional real and personal property may be used in the evaluation in determining financial assistance.
The amount of cash in savings and checking accounts will also be used in determining financial assistance.
It is the responsibility of the applicant to provide, upon request, adequate documentation of checking/savings accounts.
Acceptable documentation will consist of current bankbooks or statements.

TSH FINANCIAL ASSISTANCE CALCULATION TABLE

Based on Federal Poverty Guidelines Effective 02/2016

	A	B	C	D	E	F	G
			FAP -Level 0 100%	FAP -Level 1 90%	FAP -Level 2 80%	FAP -Level 3 70%	FAP -Level 4 60%
	Family Unit Size	FEDERAL Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)
Income Per Year	1	$11,880	$23,760	$29,700	$35,640	$41,580	$47,520
Income Per Year	2	$16,020	$32,040	$40,050	$48,060	$56,070	$64,080
Income Per Year	3	$20,160	$40,320	$50,400	$60,480	$70,560	$80,640
Income Per Year	4	$24,300	$48,600	$60,750	$72,900	$85,050	$97,200
Income Per Year	5	$28,440	$56,880	$71,100	$85,320	$99,540	$113,760
Income Per Year	6	$32,580	$65,160	$81,450	$97,740	$114,030	$130,320
Income Per Year	7	$36,730	$73,460	$91,825	$110,190	$128,555	$146,920
Income Per Year	8	$40,890	$81,780	$102,225	$122,670	$143,115	$163,560
	Each addtl.: Add	$4,160					

			FAP -Level 0	FAP -Level 1	FAP -Level 2	FAP -Level 3	FAP -Level 4
		FEDERAL	100%	90%	80%	70%	60%
	Family Unit Size	Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)
Income Per Month	1	$990	$1,980	$2,475	$2,970	$3,465	$3,960
Income Per Month	2	$1,335	$2,670	$3,338	$4,005	$4,673	$5,340
Income Per Month	3	$1,680	$3,360	$4,200	$5,040	$5,880	$6,720
Income Per Month	4	$2,025	$4,050	$5,063	$6,075	$7,088	$8,100
Income Per Month	5	$2,370	$4,740	$5,925	$7,110	$8,295	$9,480
Income Per Month	6	$2,715	$5,430	$6,788	$8,145	$9,503	$10,860
Income Per Month	7	$3,061	$6,122	$7,652	$9,183	$10,713	$12,243
Income Per Month	8	$3,408	$6,815	$8,519	$10,223	$11,926	$13,630
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		FEDERAL	100%	90%	80%	70%	60%
	Family Unit Size	Poverty Guidelines	(X2)	(X2.5)	(X3)	(X3.5)	(X4)
Income Per Week	1	$228	$457	$571	$685	$800	$914
Income Per Week	2	$308	$616	$770	$924	$1,078	$1,232
Income Per Week	3	$388	$775	$969	$1,163	$1,357	$1,551
Income Per Week	4	$467	$935	$1,168	$1,402	$1,636	$1,869
Income Per Week	5	$547	$1,094	$1,367	$1,641	$1,914	$2,188
Income Per Week	6	$627	$1,253	$1,566	$1,880	$2,193	$2,506
Income Per Week	7	$706	$1,413	$1,766	$2,119	$2,472	$2,825
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