Yale
NewHaven
Health

# Financial Assistance Programs
## Policies and Procedures

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| **Service Area:** Corporate Business Services | **YALE NEW HAVEN HEALTH SYSTEM POLICIES & PROCEDURES** |
| **Title:** Financial Assistance Programs Policy | |
| **Date Approved:** 09/20/2013 | **Approved by:** Boards of Trustees<br>Senior Vice President, Finance |
| **Date Effective:** 09/20/2013 | **Date Reviewed/Revised:** 01/21//2015, 09/30/2016 |
| **Distribution:** MCN Policy Manager | **Policy Type (I or II):** Type I |
| **Supersedes:**<br>Yale New Haven Hospital Financial Assistance Programs for Hospital Services (NC:F-4)<br>Bridgeport Hospital Financial Assistance Programs for Hospital Services (9-13)<br>Greenwich Hospital Overview of Financial Assistance Programs for Hospital Services | |

### Purpose

Yale New Haven Health System ("YNHHS") recognizes that patients may not be able to pay for medically necessary health care without financial assistance. Consistent with its mission, YNHHS is committed to assuring that the ability to pay will be considered carefully when setting amounts due for emergency and other medically necessary hospital services.

In recognition of its role to help those in need of financial assistance, YNHHS has established the Financial Assistance Programs ("FAP") to assist with emergency and other medically necessary care. The objectives of the FAP are to:

- Specify all financial assistance available under the FAP;
- Provide clear information regarding eligibility criteria, application requirements and the method for applying for financial assistance under the FAP;
- The basis for calculating amounts charged to FAP-eligible patients for emergency or other medically necessary care; and
- The YNHHS measures to widely publicize this FAP within the communities served by YNHHS.

### Applicability

This policy applies to each licensed hospital affiliated with YNHHS, including Bridgeport Hospital, Greenwich Hospital, and Yale-New Haven Hospital (each a "Hospital").

Policy

## I. Scope and Provider List

A. **Emergency and Other Medically Necessary Care**. The FAP apply to emergency and other medically necessary care, including inpatient and outpatient services, billed by a Hospital. The FAP exclude: (a) private room or private duty nurses; (b) services that are not medically necessary, such as elective cosmetic surgery; (c) other elective convenience fees, such as television or telephone charges, and (d) other discounts or reductions in charges not expressly described in this Policy.

B. **Provider List**. A list of providers who provide emergency and other medically necessary care at a Hospital can be found here: https://www.ynhhs.org/patient-care/billing-insurance/financial-assistance.aspx. The list indicates if the provider is covered under the FAP. If the provider is not covered under this policy, patients should contact the provider's office to determine if the provider offers financial assistance and if so what the provider's financial assistance policy covers.

## II. Financial Assistance Programs and Eligibility

Financial assistance is available to individuals who are residents of the United States of America, or citizens of the Unites States residing abroad, who complete a financial assistance application and meet the additional eligibility requirements described below.

A. **Free Care.** The Free Care program provides care at no cost to Hospital patients with gross annual family income less than or equal to 250% of the Federal Poverty Guidelines (*see* Attachment 1), and who have applied for, and been approved or receive a valid denial within the last six months, for State medical assistance.

In addition, YNHHS employs a third party screening tool to assist in identifying individuals with self-pay balances who have not applied for financial assistance, but who have incomes less than or equal to 250% of the Federal Poverty Level (*i.e.*, eligible for free care). If a patient is identified through this process outstanding hospital balances may be adjusted to charity (free) care.

B. **Discounted Care.** If a patient's gross annual family income is over 250% of the Federal Poverty Level, and the patient is uninsured, the Hospital will discount care to the Hospital's AGB (as defined in Section III below and on Attachment 1 hereto).

C. **Restricted Bed Funds.** You may be eligible to receive restricted bed funds, which are funds that have been donated to the Hospital to provide free or discounted care to individuals who meet the individual fund criteria. There are no specific income limits for receipt of restricted bed funds. Eligibility is determined on a case-by-case basis by the fund nominators based on financial hardship. All patients who fill out the YNHHS financial assistance application will automatically be considered for restricted bed funds.

D. **Other Hospital-Specific Financial Assistance programs:**

- **Yale New Haven Hospital Me & My Baby Program**. This program is available to Yale New Haven Hospital patients. It provides prenatal, labor and delivery services, and some post-partum care free of charge. You may be eligible if you live in New Haven County, do not have any type of health insurance and your family earns less than 2 ½ times the Federal Poverty Level. For more information or to request an application, see our representatives at the Yale New Haven Hospital Women's Center or call 203-688-5470.

- **Greenwich Hospital Outpatient Clinic** provides free or discounted care to individuals who apply for and are approved for clinic membership. You may be eligible for clinic membership if you do not have insurance, are not eligible for State Assistance (Medicaid), are a Greenwich resident and have family income less than 4 times the Federal Poverty Level. For more information or to obtain an application please call 203-863-3334.

**III. Limitation on Charges - Amounts Billed to FAP-Eligible Patients**

Where there is an award of financial assistance that does not cover 100% of YNHHS charges for the service, the amounts charged to patients eligible for financial assistance under this Policy will not be more than the amount a Hospital generally bills patients who have insurance coverage for such care ("AGB"). YNHHS calculates AGB annually by Hospital using the "look back method" and based on Medicare fee-for-service rates, including Medicare beneficiary cost-sharing amounts and all private health insurers that pay claims to each Hospital facility for the prior Fiscal Year. YNHHS may apply the percentage discount by Hospital, or may elect to use the percentage discount most favorable to YNHHS patients. AGB is set forth on Attachment I hereto.

As used herein, the "amount generally billed" and "look back method" have the meanings set forth in Internal Revenue Code §501(r)(5) and1.501(r)-5.

**IV. Method of Applying for Assistance**

To be eligible for financial assistance, the patient must complete an application for financial assistance ("Application"). The Application sets forth (i) FAP available programs and eligibility requirements, (ii) the documentation requirements for determinations of eligibility, and (iii) the contact information for FAP assistance. The Application also specifies (i) that the Hospital will respond to each Application in writing, (ii) that patients may re-apply for FAP at any time, and (iii) that additional free bed funds become available every year.

Hospitals may not deny financial assistance under the FAP based on failure to provide information or documents that the FAP or the Application do not require as part of the Application.

YNHHS Hospitals make reasonable efforts to determine eligibility and document any determinations of financial assistance eligibility in the applicable patient accounts. Reasonable efforts include suspending any extraordinary collection action to obtain payment for the care, making a determination as to whether the individual is FAP-eligible for the care and notifying him/her in writing of the eligibility determination, including, if applicable, the assistance for which the individual is eligible, and the basis for this determination.

Once Hospital identifies a patient is FAP-eligible, Hospital shall:

(i) Provide a billing statement indicating amount the individual owes as a FAP-eligible patient, including how the amount was determined and states, or describes how the individual can get information regarding the AGB for the care;

(ii) Refund to the individual any amount he or she has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than $5, or such other amount set by the IRS; and

(iii) Take reasonable measures to reverse any extraordinary collection actions.

## V. Non-Payment – Legal Action

A Hospital (and any collection agency or other party to which it has referred debt) shall not engage in any extraordinary collection action ("ECA") before making reasonable efforts to determine if a patient or any other individual having financial responsibility for a self-pay account (Responsible Individual(s)) eligible for financial assistance under this FAP. Any ECA must be approved by the Vice President of Corporate Business Services or his designee(s), prior to the initiation of any ECA.

The Hospital will follow its A/R billing cycle in accordance with internal operational processes and practices. As part of such processes and practices, the Hospital will, at a minimum, notify patients about its FAP from the date care is provided and throughout the A/R billing cycle (or during such period as is required by law, whichever is longer) by:

1. All patients will be offered a plain language summary and an application form for financial assistance under the FAP as part of the discharge or intake process from a Hospital.

2. At least three separate statements for collection of self-pay accounts shall be mailed or emailed to the last known address of the patient and any other Responsible Individual(s); provided, however, that no additional statements need be sent after a Responsible Individual(s) submits a complete application for financial assistance under the FAP or has paid in-full. At least 60 days shall have elapsed between the first and last of the required three mailings. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made. All single patient account statements of self-pay accounts will include but not limited to:

    a. An accurate summary of the hospital services covered by the statement;

    b. The charges for such services;

    c. The amount required to be paid by the Responsible Individual(s) (or, if such amount is not known, a good faith estimate of such amount as of the date of the initial statement); and

    d. A conspicuous written notice that notifies and informs the Responsible Individual(s) about the availability of financial assistance under the FAP including the telephone number of the department and direct website address where copies of documents may be obtained.

3. At least one of the statements mailed or emailed will include written notice that informs the Responsible Individual(s) about the ECAs that are intended to be taken if the Responsible Individual(s) does not apply for financial assistance under the FAP or pay the amount due by the billing deadline. Such statement must be provided to the Responsible Individual(s) at least 30 days before the deadline specified in the statement. A plain language summary will accompany this statement. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made.

4. Prior to initiation of any ECA, an oral attempt will be made to contact Responsible Individual(s) by telephone at the last known telephone number, if any, at least once during the series of mailed or emailed statements if the account remains unpaid. During all conversations, the patient or Responsible Individual(s) will be informed about the financial

assistance that may be available under the FAP.

5. Subject to compliance with the provisions of this policy, a YNHHS Hospital may take Extraordinary Collection Actions as set forth in Attachment I of this Policy, to obtain payment for medical services provided.

## VI. Policy Availability

Contact Corporate Business Services toll free at 855- 547-4584 for information regarding eligibility or the programs that may be available to you, to request a copy of the FAP, FAP application form, or Billing and Collection Policy to be mailed to you, or if you need a copy of the FAP, plain language summary, or FAP application form translated to a language other than English. Further, patients may ask Patient Registration, Patient Financial Services and Social Work/Case Management about initiating the FAP application process.

Copies of the FAP, a plain language summary of the FAP and FAP application is available at https://www.ynhhs.org/billing-insurance.aspx.

Each Hospital makes available copies of the FAP, a plain language summary of the FAP and FAP application on request, free of charge, by mail or in the Hospital Emergency Department and at all points of registration in paper form in English and the primary language of any population with limited English proficiency that constitutes 5% or more of the population the Hospital serves. See Attachment 3 for a list of languages.

Further efforts to widely publicize the FAP include publishing notices in newspapers of general circulation; providing written notice of FAP in all billing statements; providing notice of FAP in all oral communications with patients regarding the amount due; and holding open houses and other informational sessions.

## VII. Management Oversight Committee

The FAP will be overseen by a management oversight committee chaired by a Senior Vice President, YNHHS and comprised of representatives from Corporate Business Services, patient financial services, patient relations, finance, and the medical staff, as necessary. This committee will meet on a monthly basis.

### References

- Internal Revenue Code 501(c)(3)
- Internal Revenue Code 501(r)
- Conn. Gen. Stat. § 19a-673 et seq.

### Related Policies

- YNHHS Billing and Collections Policy (xx)
- Yale-New Haven Hospital Policy – Distribution of Free Care Funds NC:F-2
- Bridgeport Hospital Policy for Free Care Funds (9-14)

Attachment I

**250% of the Federal Poverty Guidelines (FPG):**

| Family size: | Maximum Income: |
|---|---|
| 1 | $29,700 |
| 2 | $40,050 |
| 3 | $50,400 |
| 4 | $60,750 |
| 5 | $71,100 |
| 6 | $81,450 |

**Add* ***$10,400*** *for each additional family member*

**Amounts Generally Billed (AGB):**
Patients eligible for financial assistance under this Policy will receive assistance according to the following:

| Annual Family Income | Amount of Discount % of Charges | Patient Pays % of Charges |
|---|---|---|
| < or = 250% FPG | 100% | 0 |
| > 250% FPG | 69% | 31%* |

**For calendar year 2016, AGB (% of charges: BH 68%, GH 68%, YNHH 67%. Financial assistance under the discounted care program across all Hospitals is 69%..*

Attachment II

**Extraordinary Collection Actions:**

Property Liens.

Liens on personal residences are permitted only if:

(i) The patient has had an opportunity to apply for free bed funds and has either failed to respond, refused, or been found ineligible for such funds;

(ii) The patient has not applied or qualified for other financial assistance under the Hospital's Financial Assistance Policy, to assist in the payment of his/her debt, or has qualified, in part, but has not paid his/her responsible part;

(iii) The patient has not attempted to make or agreed to a payment arrangement, or is not complying with payment arrangements that have been agreed to by the Hospital and patient;

(iv) The aggregate of account balances is over $10,000 and the property(ies) to be made subject to the lien are at least $300,000 in assessed value; and

(v) The lien will not result in a foreclosure on a personal residence.

# Limited English Proficiency Languages

| |
|---|
| Albanian |
| Arabic |
| Simplified Chinese |
| French |
| French Creole (Haitian Creole) |
| German |
| Greek |
| Hindi |
| Italian |
| Japanese |
| Korean |
| Pashto |
| Persian Dari |
| Persian Farsi |
| Polish |
| Portuguese |
| Portuguese Creole (Cape Verdean) |
| Russian |
| Spanish |
| Swahili |
| Tagalog |
| Tigrinya |
| Turkish |
| Vietnamese |

Yale NewHaven Health

# Summary of Financial Assistance Policy

Yale New Haven Health understands that it can be difficult for some patients to afford paying their hospital bills. That is why we have a variety of financial assistance programs designed to help. Patients are required to complete a financial assistance application and provide requested documents to verify financial need.

To learn more, obtain a free copy of our Financial Assistance Policy and application, or for help completing an application contact Patient Financial and Admitting Services at 855-547-4584, go to ynhhs.patientsimple.com or visit us in our Admitting offices at: Yale New Haven Hospital 20 York Street, New Haven, CT; Bridgeport Hospital 267 Grant Street, Bridgeport, CT; or Greenwich Hospital, 5 Perryridge Road, Greenwich, CT.

## Free care

**You may be eligible for free care if:**

- Your family earns less than or equal to 2½ times the Federal Poverty Level (the maximum income amounts are listed on the table below)
- You apply for State Assistance (Medicaid) and receive a
- valid written decision from the State within the last 6 months; and
- You complete a financial assistance application

| **Family size:** | **Maximum Income:** |
|---|---|
| 1 | $29,700 |
| 2 | $40,050 |
| 3 | $50,400 |
| 4 | $60,750 |
| 5 | $71,100 |
| 6 | $81,450 |

**Add **$10,400** for each additional family member*

## Discounted care

You may be eligible for discounted care if you are uninsured and you complete an application for financial assistance.

## Restricted bed funds

You may be eligible to receive restricted bed funds, funds that have been donated to provide free or discounted care to individuals who meet individual fund criteria, to reduce or eliminate your hospital bill if you have a demonstrated financial need as determined by a fund's nominator; and you meet all eligibility criteria to receive funds (each fund has unique criteria). There are no specific income limits for receipt of restricted bed funds. Eligibility is determined on a case-by-case basis by the fund nominators based on financial hardship. All patients who fill out the financial assistance application will automatically be considered for restricted bed funds.

## Yale New Haven Hospital "Me & My Baby" Program

This program is applicable to Yale New Haven Hospital patients. It provides prenatal care, labor and delivery services, and some post-partum care free of charge to those who qualify. You may be eligible if you live in New Haven County; do not have any type of health insurance; your family earns less than 2½ times the Federal Poverty Level (see maximum income chart above); you apply for State Assistance (Medicaid) and receive a valid written decision from the State. For more information or to request an application for the Yale New Haven Hospital Me & My Baby Program, see our representatives at the Women's Center or call **203-688-5470.**

## Greenwich Hospital Outpatient Clinic

The Greenwich Hospital Outpatient Clinic provides free or discounted care to individuals who apply for and are approved for clinic membership. If you do not have insurance, and are not eligible for State Assistance (Medicaid), you may be eligible if you are a Greenwich resident and have family income less than 4 times the Federal Poverty Level. For more information or to obtain an application please call **203-863-3334.**

## A note about the programs

You must be a citizen or resident of the United States to be eligible for financial assistance. These programs cover emergency or other medically necessary care. They cover ONLY Yale New Haven Health member hospital bills. A link to the list of providers who provide such care and whether they do or do not follow the FAP can be found in the FAP. Patients eligible for financial assistance will not be charged more than the amount generally billed to patients with insurance for emergency or other medically necessary care. Yale New Haven Health will respond to each application in writing. If your application is denied, you can re-apply at any time. Additional free bed funds become available every year. Translations of our Financial Assistance Policy, Summary of Financial Assistance Policy and Application are available for certain groups with limited English proficiency.

Please call 1-855-547-4584 for help.

## A note about the Free Care program

In order to be considered for Free Care, you MUST apply for Medical Assistance (Medicaid) in the state where you live and receive a valid, written decision on your application within the last 6 months. Please submit this decision with your application. If you are applying for Discounted Care, you must not presently have any type of health insurance. Discounted care applications do not require an attached state decision letter.

## How do I apply for financial assistance?

To make the process easy for patients, Yale New Haven Hospital, Bridgeport Hospital and Greenwich Hospital use one application form for most financial assistance programs. If you are a Yale New Haven Hospital patient and wish to apply for the Me & My Baby Program, please contact our Women's Center representatives at 203-688-5470. If you are a Greenwich Hospital patient and wish to apply for the Outpatient clinic, please contact at 203-863-3334.

**Note:** You must have current hospital bills or a scheduled appointment at the hospital to qualify for our financial assistance programs.

Free Care Program: Follow steps 1, 2, 3 and 4.

Discounted Care Program: Follow steps 2, 3 and 4.

Step 1: Apply for State Medical Assistance.
To be eligible for Free Care, you MUST apply for Medical Assistance (Medicaid) in the state where you live and receive a valid, written decision on your application. A denial is not "valid" if it was issued because you did not provide information or cooperate.

You can apply for Medicaid at your local Department of Social Services (DSS) office. CT residents call 1-800-842-1508 to find the DSS office nearest to you or apply online at www.accesshealthct.com. The hospital also has staff that can help you fill out the applications. If you need assistance, call us at 1-855-547-4584.

Once you receive a written decision from DSS, you may apply for Free Care. We cannot accept decision letters that are greater than 6 months old.

Step 2: Complete the Application.
Please answer ALL questions and sign and date the application. If a question does not apply to your family, please write "N/A" (not applicable) in the space provided.

Step 3: Attach proof of income to your application. Proof of income is a document that shows how much income your family earns at the time you fill out the application. See the table on right for the types of documents that may be used.

Step 4: Mail the application. Include: 1) The decision letter from DSS about your eligibility for State Assistance; 2) The completed, signed and dated application; and 3) Proof of income to:

Yale New Haven Health
SBO, Attn: Financial Assistance
PO BOX 1403
New Haven, CT 06505

## The following documents may be used as proof of income:

| If your family's income is from ... | You may attach copies of these documents as proof of income: (These documents must not be more than six months old, except for your most recent Federal Tax Return, which may be older.) |
|---|---|
| Wages (If you earn a salary or get paid by the hour for a job) | – Two (2) of the most recent pay stubs, **OR**<br>– A letter from your employer on company letterhead stating how many hours you work and how much you earn per hour (before taxes) |
| Self-employed income (If you work for yourself) | – Most recent Federal Income Tax Return (must be signed by you) |
| Benefits (Social Security, Veteran's, Worker's Compensation, Unemployment, Pensions, Retirement funds, SSI, alimony) | – Most recent benefits award letter, **OR**<br>– Benefits Statement, **OR**<br>– Check stubs |
| Rental Income | – Copy of lease or written agreement showing amount of rent, **OR**<br>– A letter written by you , indicating the amount of rent you receive per year |
| Interest, Dividends, or Annuity Payments | – Most recent Federal Income Tax Return, **OR**<br>– Statement from financial institution stating the amount and the frequency of payments and the amount paid this year to date |
| If you have no income | – A letter from the person who supports you, **OR**<br>– If you do not have a person who supports you, send a signed and dated letter explaining your current financial situation |

## Application for Financial Assistance Programs

Yale New Haven Hospital, Bridgeport Hospital and Greenwich Hospital use one application form for most financial assistance programs. By completing this application you will be considered for our Free Care, Discounted Care, and Bed Fund programs. For instructions on how to apply for financial assistance, please refer to page 2. Any questions about this application, please call 1-855-547-4584.

Yale NewHaven Health

### 1. Patient Information:

Last Name _____ First Name _____ Social Security Number _____

Street Address _____ Date of Birth _____

City _____ State _____ Zip Code _____ Telephone Number _____

If you are pregnant, what is your due date? _____ Medical Record Number (if available) _____

Legal status: ☐ U.S. Citizen ☐ U.S. Resident (attach identification) ☐ Visa (student, work, visitor)
☐ Non U.S. Citizen

### 2. Family Information:

List your spouse and/or any dependent children living in your household. Do not include non-married partners. If more space is necessary, please attach a separate document.

| Name of family member | Social Security Number | Relationship to applicant | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

### 3. Income Information:

**Income information for you and your spouse must be provided.** Include all sources of income. Sources of income may include but are not limited to: wages/salary, alimony, social security, unemployment, rental income, worker's compensation, and child support. If you have no income, attach a letter of support to your application. (See instructions on Page 2)

| Name of family member | Source of income | Amount earned before tax (circle) |
|---|---|---|
| | | $_____ week/bi-week/month/year |
| | | $_____ week/bi-week/month/year |
| | | $_____ week/bi-week/month/year |

## 4. Health Insurance:

Are you covered under any health insurance policy, including Medicare or Medicaid or coverage from a foreign country? ☐ YES ☐ NO

If **yes**, please attach a copy of the front and back of your insurance card to this application OR enter the following:

| | | |
|---|---|---|
| **Policy Holder:** | **Insurer:** | **Policy No.:** |
| **Policy Holder:** | **Insurer:** | **Policy No.:** |

## 5. Restricted bed funds: Please select any that apply. If you have a financial hardship that you would like us to consider when reviewing your application, please attach a letter describing your situation.

- ☐ A person who lives in Shelton
- ☐ A person who lives in Hamden
- ☐ A person who lives in Southington
- ☐ A person who lives in Greenwich
- ☐ A child who lives in Guilford or North Branford
- ☐ A women in financial need
- ☐ A person of German heritage
- ☐ A child in financial need
- ☐ A person with throat or lung disease
- ☐ A veteran of World War II
- ☐ A child at the Children's Center in Hamden

## 6. Please read carefully before signing:

By signing below, I certify that everything I have stated on this application and any attachment is true.

- I understand that any incorrect, incomplete, or false information on this form could result in rejection of my application for financial assistance.
- I give Yale New Haven Health permission to verify any and all information.
- I give Yale New Haven Health permission to request my credit report.
- I agree to repay the full amount of my financial assistance award if I receive payment of any kind, including awards from a lawsuit, for the services covered by this application.
- I agree to inform Yale New Haven Health of any changes that could change my eligibility for financial assistance.
- I understand that in connection with my application for financial assistance, Yale New Haven Health may need to disclose Protected Health Information (as that term is defined in the HIPAA Privacy Rule, 42 CFR Parts 160 through 164) about me in order to determine my eligibility.
- I understand that any such disclosure will be for payment purposes, as defined in the HIPAA Privacy Rule.

_____ _____

Signature of person applying or legal guardian Date

_____

Printed name of the person applying or legal guardian

**Please remember to attach a valid written decision of your Medicaid Assistance (Medicaid) application from the state in which you live and proof of income OR a letter of support to your application if applicable.**

***Please mail the completed application to:***

**Yale New Haven Health**
SBO, Attn: Financial Assistance
PO BOX 1403,
New Haven, CT 06505