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: **Bridgeport Hospital** 267 Grant Street, Bridgeport, CT; **Greenwich Hospital**, 5 Perryridge Road, Greenwich, CT; **Lawrence + Memorial Hospital** 365 Montauk Avenue, New London, CT; **Westerly Hospital** 25 Wells Street, Westerly, RI; or **Yale New Haven Hospital** 20 York Street, New Haven, 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	$30,150
2	$40,600
3	$51,050
4	$61,500
5	$71,950
6	$82,400

Add **$10,450 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, Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Hospital, Westerly Hospital and Yale New Haven 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** – 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** – Benefits Statement, **OR** – Check stubs
Rental Income	– Copy of lease or written agreement showing amount of rent, **OR** – 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** – 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** – 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 NewHaven Health

Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Hospital, Westerly Hospital and Yale New Haven 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.

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.

Mail the completed application to:

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