Financial Assistance Policy Plain Language Summary

Yale New Haven Health (YNHHS) provides financial assistance for emergency and/or medically necessary care to uninsured and underinsured patients who meet the following criteria:

If you live in the United States and are (a) uninsured and not eligible for any government health care benefit program or a qualified health plan available through the Affordable Care Act, or (b) underinsured:

Free care

You may be eligible for a full (100%) discount off the amount you owe if:

- Your family earns less than or equal to 250% of the Federal Poverty Level.

Discounted care

You may be eligible for a partial discount off the amount you owe if:

- Your family earns less than or equal to 550% of the Federal Poverty Level.

Medically Indigent

Consideration for financial assistance also may be given to patients on a case by case basis who do not meet the income criteria above, but whose medical bills exceed a certain percentage of the family's income or assets.

FAQs

What are the maximum income levels to qualify for the programs?

For details on the maximum income levels of each program, visit www.ynhhs.org/financialassistance.

Are there other qualifications for financial assistance?

To be eligible you must cooperate in completing the financial assistance application and applying for Medicaid or any other third-party payment programs that may be available.

What is covered under financial assistance?

Our financial assistance programs cover emergency and other medically necessary care for Yale New Haven Health bills only. A link to the list of covered providers can be found at www.ynhhs.org/financialassistance.

How will I know if my application is approved?

We will respond to each application in writing. If your application is denied, you can re-apply at any time. Additional hospital bed funds become available every year.

How to Apply and Where to Obtain Copies

To apply, obtain an application, complete the required information and return the application to one of our financial assistance offices located below.

You can access a free copy of the Application, Financial Assistance Policy and this Plain Language Summary at www.ynhhs.org/financialassistance or any of the YNHHS hospital websites, by mail by calling Patient Financial and Admitting Services at 855-547-4584, or in person at the registration areas, including the Emergency Departments, at all of our hospital facilities.

Availability of Translation Services

For certain groups with limited English proficiency, translations of our Financial Assistance Policy, Financial Assistance Application and this plain language summary of the Financial Assistance Policy are available on the website www.ynhhs.org/financialassistance and at the hospital locations listed below.

Who can I contact if I have additional questions?

To learn more or for help completing an application, contact Patient Financial and Admitting Services at **855-547-4584**.

Additional Program Details

Hospital bed funds

A patient may be eligible to receive financial assistance from bed funds donated to a Yale New Haven Health hospital to provide medical care to patients who may be unable to afford hospital care. These funds make up a small portion of the overall funding for financial assistance with eligibility taking into account donor-restrictions and, if applicable, nominations made by fund nominators. All patients who fill out a financial assistance application will automatically be considered for hospital bed funds.

Limitation on Charges

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.

Bridgeport Hospital
267 Grant Street, Bridgeport, CT

Bridgeport Hospital – Milford Campus
300 Seaside Ave, Milford, CT

Greenwich Hospital
5 Perryridge Road, Greenwich, CT

Lawrence + Memorial Hospital
365 Montauk Avenue, New London, CT

Westerly Hospital
25 Wells Street, Westerly, RI

Yale New Haven Hospital
20 York Street, New Haven, CT

Yale New Haven Hospital – St. Raphael Campus
20 York Street, New Haven, CT

How do I apply for financial assistance?

To make applying for financial assistance easier, Yale New Haven Health uses one application for its financial assistance program. To apply, complete the steps below.

Step 1: 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 2: 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 the right for the types of documents that may be used.

Step 3: Mail the application or visit us in person. Please include:

1. The completed, signed and dated application
2. Proof of income

By mail:

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

By fax: 203-688-1640

In person:

Visit us at any of our locations below:

Bridgeport Hospital
267 Grant Street, Bridgeport, CT

Bridgeport Hospital – Milford Campus
300 Seaside Ave, Milford, CT

Greenwich Hospital
5 Perryridge Road, Greenwich, CT

Lawrence + Memorial Hospital
365 Montauk Avenue, New London, CT

Westerly Hospital
25 Wells Street, Westerly, RI

Yale New Haven Hospital
20 York Street, New Haven, CT

Yale New Haven Hospital – St. Raphael Campus
20 York Street, New Haven, CT

To learn more, obtain a free copy of our Financial Assistance Policy, or for help completing an application.

By phone:
855-547-4584
M-F 7:30 am – 5 pm

Online:
www.ynhhs.org/financialassistance

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
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 New Haven Health uses one application for most financial assistance programs. By completing this application, you will be considered for our Free Care and Discounted Care programs and hospital bed funds. For instructions on how to apply for financial assistance, please refer to page 2. If you have any questions about this application, call us at **855-547-4584**.

1. Patient Information:

Last Name _____ First Name _____ Date of Birth _____

Street Address _____ Telephone Number _____

City _____ State _____ Zip Code _____ Medical Record Number (if available) _____

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	Relationship to applicant	Date of Birth

3. Financial Information: Include information on all sources of income for you and your spouse. Please remember to 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. Refer to the table on page 2 for the types of documents that may be used as proof of income.

Income	**Patient** Enter Amount Circle: Weekly, Biweekly, Monthly	**Spouse** Enter Amount Circle: Weekly, Biweekly, Monthly
Gross Wages/ Earnings (Before Taxes)		
Supported by Other Individual		
Child Support/ Alimony Received		
Disability Benefits		
Pension Benefits		
Rental Income Received		
Self-Employment or Farm Earnings		
Social Security/ SSI Benefits		
Trust Funds/ Inheritance		
Unemployment Benefits		
Workman's Compensation		
TOTAL INCOME		
OTHER		
Liquid Assets (assets that can be exchanged for cash on short notice, without losing value. For example, cash, gold, or marketable securities)		

4. Health Insurance:

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

If **yes**, please enter your insurance information below:

Policy Holder:	**Insurer:**	**Policy No.:**
Policy Holder:	**Insurer:**	**Policy No.:**

4a. Does your employer sponsor a Health Saving Account (HSA) fund to help pay for your medical expenses?
☐ YES ☐ NO

5. 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 (MM/DD/YYYY)

_____

Printed name of the person applying or legal guardian

Remember to include proof of income or a letter of support with your financial assistance application.

Mail completed applications to:

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