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 medical 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.

Free care

You may be eligible for free care if:

- Your family earns less than or equal to 2 1/2 times the Federal Poverty Level; and
- You complete a financial assistance application

Discounted care

You may be eligible for discounted care if:

- Your family earns less than or equal to 5 1/2 times the Federal Poverty Level;
- You are uninsured; and
- You complete a financial assistance application

Sliding scale

You may be eligible for sliding scale if:

- Your family earns less than or equal to 5 1/2 times the Federal Poverty Level;
- You are insured; and
- You complete a financial assistance application

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?

In addition to meeting the income qualifications, you must be a citizen or resident of the United States to qualify.

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 long will I be eligible for?

Once approved for Free Care, Discounted Care, or Sliding Scale, you will be eligible for 12 months from the date of the approved application.

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 free bed funds become available every year.

Who can I contact if I have additional questions?

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**.

Additional Program Details

Restricted bed funds

Restricted bed funds have been donated to provide free or discounted care to individuals who meet individual fund criteria. You may be eligible to receive these funds to reduce or eliminate your 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 YNHHS financial assistance application will automatically be considered for restricted bed funds.

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:

1. You are a Greenwich resident
2. You have family income less than or equal to 4 times the Federal Poverty Level.

For more information or to obtain a Greenwich Hospital Outpatient Clinic application, please call 203-863-3334.

A note about the programs

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. Translations of our Financial Assistance Policy, Summary of Financial Assistance Policy and Application are available for certain groups with limited English proficiency.

How do I apply for financial assistance?

To make applying for financial assistance easier, Yale New Haven Health uses one application for most financial assistance programs. 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, Discounted Care, Sliding Scale and Bed Fund programs. 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**.

Yale NewHaven Health

1. Patient Information:

Last Name First Name

Street Address

City State Zip Code

Date of Birth

Telephone Number

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. Income Information:

Include information on all sources of income for you and your spouse. Income information for you and your spouse must be provided. 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 taxes	Unemployed / No Income
		$ Weekly Bi-weekly Monthly	☐
		$ Weekly Bi-weekly Monthly	☐
		$ Weekly Bi-weekly Monthly	☐

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. 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

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