STAMFORD HEALTH

FINANCIAL ASSISTANCE POLICY

PURPOSE

The purpose of this Policy (the "**Policy**," or "**FAP**") is to describe the Financial Assistance Program (the "**Program**") of The Stamford Hospital (the "**Hospital**"). The Program has been adopted to ensure that all requests for financial assistance are evaluated and processed consistently and fairly in support of the Hospital's mission, i.e., to provide a broad range of high quality health and wellness services focused on the needs of our community.

NOTICE AND DISSEMINATION OF THE POLICY AND APPLICATION

The community will be notified of and provided with access to this Policy as follows:

1. *Summary Provided Upon Registration in the Emergency Room*. Upon registration in the Emergency Room, all patients are offered a copy of the Financial Assistance Plain Language Summary of the Policy (the "**Summary**"), which shall also be made available upon request. The Summary provides information on how patients may obtain the full Policy, a FAP application form (the "**Application**"), and additional information about the Program. The Summary shall also be located in public displays in various locations within the Hospital, including, at a minimum, the Emergency and Admissions Departments and waiting rooms.

2. *Dissemination to the Community*. The Hospital will notify the community about the Policy and Program in a manner designed to reach those who are most likely to require financial assistance from the Hospital (e.g., by distributing copies of the Summary to the Hospital's affiliated clinics). As noted above, the Hospital will make the Policy, the Application, and the Summary available on its web site. Such documents shall also be provided by mail at no charge upon request.

3. *Notice on Billing Statements*. The Hospital shall include inserts with billing statements, which shall also contain a conspicuous notice informing recipients about the availability of financial assistance under the Program. Such notice includes the telephone number of the Hospital's Patient Business Services Department (which will provide information about the Program and the FAP application process), and the direct web site address (or URL) where copies of the Policy, Application, and Summary may be obtained.

SCOPE AND APPLICABILITY

1. *Who is Eligible for Financial Assistance **("Eligible Individuals")**?*

In order to be eligible to participate in the Program, an individual must meet both of the following criteria:

A. The individual must be uninsured or under-insured, and *ineligible* for a Federal or State program or a qualified health plan available through the Affordable Care Act (the "**Insurance Criteria**") [1]; and

B. The individual must have a gross annual household income that does not exceed 400% of the current US Department of Health and Human Services Federal Poverty Guidelines ("**FPGs**") for his/her family size (the "**Income Criteria**").

Individuals who meet the Insurance Criteria and the Income Criteria shall be referred to herein as "Eligible Individuals."

2. *What are the Services for which Eligible Individuals may Receive Financial Assistance Under the Program?*

A. **Eligible Services**. Financial assistance is available to help reduce the financial burden on Eligible Individuals of emergency and medically necessary services ("**Eligible Services**"). Cosmetic, experimental, and convenience services are not considered emergent or medically necessary under the Program and are therefore not Eligible Services. The Hospital will provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are Eligible Individuals. The Hospital will not engage in actions that discourage individuals from seeking emergency medical care.

B. Presumptive Eligibility: If Stamford determines through a third-party verification database that a patient has annual family income at or under 200% of the FPG, that patient will be deemed eligible for financial assistance without further information or documentation at scheduling or prior to admission.
- External billing and collection agencies
- Credit Bureaus
- Propensity to pay scoring model
- FICO Score Information
- Patients are presumed to be eligible for financial assistance based on individual life circumstances including but not limited to:

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[1] For clarity, individuals who are eligible for any form of insurance but do not or will not apply are not Eligible Individuals under this Policy, provided, however, that consistent with Connecticut Public Act 03-266, any Uninsured (as defined by the Act), individuals who are not Eligible Individuals but have incomes (without regard to available assets) below 250% of the FPGs will not be charged more than the Hospital's cost of providing services to the patient.

- Patients discharged to a SNF
- Patient is deceased with no known estate and below 200% FPL
- State-funded prescription programs
- Homeless or received care from a homeless clinic
- Participation in women, infants, and children programs WIC, Food stamp eligibility
- Subsidized school lunch programs eligibility
- Eligibility for other state or local assistance programs that are unfunded (E.G Medicaid spenddown)
- Patients that are referred through a National Association for free clinics
- Medicaid Eligible patients, when the following criteria apply, Medicaid eligibility requirements are met after the service is provided, Non-Covered charges occur on a Medicaid eligible encounter; and The provider is not credentialed or contracted
- Low income subsidized housing is provided as a valid address, or other significant barriers are present

C. Catastrophic expenses fall under the FAP if a patient's responsibility of uncompensated charged exceed 25% of the total annual family income and or assets. A review of the patient's financial position will be done to determine eligibility under this provision

Eligible Providers. The Program provides financial assistance for the provision of Eligible Services to Eligible Individuals by the Hospital and certain other providers of Eligible Services in the Hospital. Lists of those providers who are and those who are not covered by this Policy can be found on the Hospital's website, http://stamfordhealth.org/patients-visitors/fap/("**View Providers")**. These lists will be reviewed and revised periodically.

THE APPLICATION PROCESS

Except as provided at the end of this Policy, a determination of eligibility for, and amount of, any financial assistance will be made only upon submission of a completed Application accompanied by required documentation.

1. *Requesting the Application*. A request for financial assistance may be made 240 days from when the first statement was mailed to the patient. This means that an individual may make a request before, during, or after services are received, including after commencement of a collection agency action against the individual. Initial requests for financial assistance may be made in writing or by telephone. Upon a request for financial assistance, the individual shall be advised of this Policy and sent a copy of the Application and Summary. If the individual speaks limited or no English, these documents will be provided in each language spoken by each significant population with limited English proficiency in the community served by the hospital.

2. *Contents of the Application*. The Application requests the following information: A.

To identify the applicant:

Date of Request
Name
Address
Telephone number
Requested by (parent or guardian if patient is a minor)
Date of birth
Social Security number*

*If available

B. **To verify that the applicant is an Eligible Individual**:

Pay stubs 3 months or 12 months
Proof of unemployment compensation
Federal tax return including all pages
Proof of any Federal or State benefits
Bank account or investment statements for 3 or 12 months
Notarized Self-Attestation as proof of income

3. *Completing the Application.* An application may be completed by an Eligible Individual or his or her legal guardian. If you have any questions regarding or need assistance with completing the Application, please contact the Hospital's Patient Business Services Department at the telephone number and address set forth below.

4. *Submission of the Application*. The application can be submitted via email to Stamfordcharity@ensemblehp.com or by mail PO BOX 9317 Stamford CT 06904

5. *If the Application is Incomplete.* If the Hospital receives an incomplete Application, it shall, within thirty (30) days of receipt, notify the applicant of such fact in writing by regular mail, sent to the address the Hospital has on file for the applicant. The notice shall specify the missing information needed. The applicant shall be given at least thirty (30) additional days to submit the missing information or may call Patient Business Services to discuss any missing information with the assigned Financial Assistant Associate.

DETERMINING ELIGIBILITY FOR AND AMOUNT OF FINANCIAL ASSISTANCE

The Hospital will follow the procedures listed below when reviewing an application. Determinations will be handled on a case-by-case basis, and shall be processed in accordance with the following:

1. *Eligibility*. The Hospital will determine whether the individual meets the Insurance Criteria and the Income Criteria as described above, and is therefore an Eligible Individual, based on the contents of the Application.

2. *Amount of Financial Assistance*. Assuming the applicant is determined to be an Eligible Individual (eligible to receive financial assistance), the Hospital will then determine the amount of assistance to be provided.

   A. **Sliding Scale to Determine Eligible Individual Obligation.** First, the Hospital shall determine the amount for which the Eligible Individual would be responsible before financial assistance is applied. This is referred to as the "**Eligible Individual Obligation**" as follows:

      i. For uninsured Eligible Individuals, the Eligible Individual Obligation is the gross account charges.

      ii. For under-insured Eligible Individuals, the Eligible Individual Obligation is the sum of any deductible, copayment, and coinsurance obligation of the Eligible Individual.

   B. **Determination of Discount Off Eligible Individual Obligation.** The discount to be provided to the Eligible Individual Obligation shall be determined according to the following sliding scale; the discounts indicated will apply to the Eligible Individual Obligation, dependent upon income level:

250% of FPG and below	100% discount
251% of FPG to 300% of FPG	90% discount
301% of FPG to 350% of FPG	80% discount
351% of FPG to 399% of FPG	70% discount
400% of FPG	60% discount

   C. **Charity Adjustment approvals**
   Less than $5,000 – Auto Approved
   Greater than $5,000 – less than $25,000 supervisor approval
   Greater than $25,000 – less than $50,000 Manager approval
   Greater than $50,000 – Director approval or above

Limit on Amounts to be Charged - No Eligible Individual to be Charged More than Amounts Generally Billed ("AGB"). Regardless of the discount level determined above, in no event will an Eligible Individual be charged more than the amounts generally billed ("AGB") for Eligible Services. The Hospital calculates its AGB on an annual basis using the "Look Back Method" based on commercial health insurance and Medicare rates. The net amount to be billed to an Eligible Individual will be determined by (i) calculating the gross charges for services rendered to the patient, and (ii) applying the appropriate discount as referenced above. A document with the current AGB calculations is available on the Hospital's website https://stamfordhealth.org/patients-visitors/fap/ and is available free of

charge by mail. You may also request a copy of the current AGB calculations by emailing our Customer Service Department at stamfordcorr@ensemblehp.com, by calling Customer Service at (203) 210-9020, by fax at (203) 276-7093 or in person at: Patient Business Services, One Hospital Plaza, Stamford, CT 06902. The AGB calculation is available in each language spoken by each significant population with limited English proficiency in the community serviced by the Hospital.

3. *Notice of Determination/Appeal of Denial*. The Hospital's determination of eligibility and the level of financial assistance, if any, shall be made within thirty (30) days after the receipt of a complete Application. All written notices or communications by the Hospital under this Policy may be provided by electronic mail or other forms of electronic communication if the individual has indicated that he or she prefers to receive notices and communications electronically.

   A. **Notice of Approval.** After reviewing a completed Application and making a determination to provide financial assistance, the Hospital shall send or give the Eligible Individual or his/her legal guardian a Financial Assistance Approval Letter. The letter of approval will provide patient with the percentage of adjustments and date span of approval. The letter will be mailed or uploaded via MyChart.

   B. **Notice of Denial**. After reviewing a completed Application and making a determination to deny financial assistance, the Hospital will send or give the applicant or his/her legal guardian a Financial Assistance Denial Letter specifying the reason for the denial.

The Hospital will file copies of the notices (denial or approval) with the completed Application.

4. *Appeal Process***.** Patients may appeal the denial of financial assistance or the level of financial assistance offered. Patients may initiate an appeal by calling, emailing, or writing to their assigned Financial Assistance Associate, or setting up an in person appointment at the Patient Business Services Department. If the patient files an appeal, the Patient Business Services Department staff will re-review the individual's documentation, including any newly submitted material, and will again document its approval or denial and notify the patient in accordance with this section, within thirty (30) days of the submission of an appeal.

ONCE A FINAL APPROVAL HAS BEEN ISSUED

1. *Duration of Financial Assistance*. Eligible Individuals shall remain eligible (without the need for any further action) at the level of assistance so determined, for one (1) year from the later of the date of initial determination, or the date of determination following the completion of an appeal if an appeal was made.

Notwithstanding the foregoing:

A. **Negative Change in Circumstances**. in the event of a change of circumstances due to which the Eligible Individual believes that additional financial assistance is needed, the Eligible Individual may apply for financial assistance again during the one (1) year period and may be provided with additional financial assistance under the Policy, if applicable.

B. **Positive Change in Circumstances**. It is expected that if an Eligible Individual receiving financial assistance has a substantial change in circumstances (such as changing from uninsured to insured status); the Eligible Individual will notify the Patient Business Services Department at the telephone number set forth below, so that this may be taken into account in the future. Such positive changes in circumstances will not be applied to reduce any financial assistance already awarded. For clarity, Eligible Individuals need not report minor changes in circumstances but rather must report only those changes that would clearly impact the financial assistance determination on a prospective basis.

2. *Provision of False or Misleading Information*. If the Hospital learns that an applicant for financial assistance provided materially false or misleading information in the Application process, such information may be taken into account by the Hospital in its review of the Application or the continued eligibility for financial assistance.

3. *Payment Plans*. Use of payment plans is permitted for the payment of Eligible Individual Obligations. Such plans shall be limited to a maximum duration of 1 year, provided that exceptions may be evaluated on a case-by-case basis. No interest shall be charged under a payment plan.

4. *Third Party Charitable Programs*. If an Eligible Individual is referred to the Hospital through a recognized third-party charitable outreach program that offers terms and conditions that differ from the foregoing, the Hospital may participate in such program, and this Policy will be deemed amended as necessary.

COLLECTION ACTIVITIES

All Hospital collection activities are described and explained in the Billing and Collection Policy. The Billing and Collection Policy is also available on the Hospital's website https://stamfordhealth.org/patients-visitors/fap/ and is available free of charge by mail. If the individual speaks limited or no English, these documents will be provided in each language spoken by each significant population with limited English proficiency in the community served by the hospital.

REPORTING AND COMPLIANCE

The Hospital will submit required reports to the State of Connecticut with regard to the Program.

An authorized Hospital employee conducts periodic reviews of Program determinations to ensure compliance with this Policy and the Billing and Collection Policy.

CONTACT INFORMATION

For more information about the Financial Assistance Program or to request a Financial Assistance Application, contact the Patient Business Services Department at the address and telephone number set forth below to speak with a Financial Assistance Associate. Foreign language translation in each language spoken by each significant population with limited English proficiency in the community served by the hospital will be provided if requested.

PATIENT BUSINESS SERVICES
DEPARTMENT

Stamford Health
One Hospital Plaza
Stamford, CT 06902

Telephone: (203) 276-7572
Fax: (203) 276-7093
Email address: Stamfordcharity@ensemblehp.com