STAMFORD HEALTH
Healing. Reimagined.

经济援助政策

目的

本政策（“**政策**”或“**FAP**”）的目的是描述斯坦福医院（“医院”）的经济援助计划（“**计划**”）。该计划已被采用，以确保对所有财务援助请求进行一致和公平的评估和处理，以支持医院的使命，即提供范围广泛的高质量健康和保健服务，专注于我们社区的需求。

政策和申请的通知和传播

社区将被通知并提供访问本政策的权限如下:

1. *在急诊室登记时提供的摘要。*在急诊室登记后，所有患者都会收到一份本政策的经济援助简明语言摘要（ “**摘要**”），其也可应要求提供。摘要提供有关患者如何获得完整的政策、FAP 申请表（“**申请**”）以及有关该计划的其他信息。摘要还应放置在医院内不同地点的公共展示区，至少包括急诊科和入院科以及候诊室。

2. *向社区傳播。*医院将以旨在覆盖最有可能需要医院经济援助的人士的方式将政策和计划通知社区（例如，通过将摘要的副本分发给医院的附属诊所）。如上所述，医院将在其网站上提供政策、申请和摘要。此类文件也应根据要求通过邮件免费提供。

3. *账单通知。*医院应包括附有账单的插页，其中还应包含显眼的通知，告知接受者根据该计划可以获得经济援助。此类通知包括医院患者业务服务部的电话号码（将提供有关计划和 FAP 申请流程的信息），以及從直接网站地址（或 URL）可以取得政策、申请和摘要副本。

范围和适用性

1. *谁有资格获得经济援助（**“合格个人”**）？*

为了有资格参与该计划，个人必须同时满足以下两个条件：

A. 个人必须未投保或投保不足，并且*没有资格*参加联邦或州计划或通过“平价医疗法案”提供的合格健康计划（**“保险标准”**）[1]；以及

B. 据个人的家庭规模（“**收入标准**”），其家庭年总收入不得超过当前美国卫生与公共服务部联邦贫困指南 (“**FPG**”) 的 400%。

符合保险标准和收入标准的个人在此称为“合格个人”。

2. *符合条件的个人可以根据该计划获得哪些经济援助服务？*

A. **合格服務。**经济援助可用于帮助符合条件的个人减轻紧急和医疗必要服务（**“符合条件的服务”**）的经济负担。根据该计划，美容、实验和便利服务不被视为紧急或医学上必需的，因此并非合格服务。医院将非歧视地向个人提供紧急医疗状况的护理，无论他们是否符合条件。医院不会采取阻止个人寻求紧急医疗护理的行动。

合格提供者。本计划为医院和医院内某些其他合格服务提供者向合格个人提供合格服务提供经济援助。可在医院网站 http://stamfordhealth.org/patients-visitors/fap/（“**查看提供者**”）上找到本政策涵盖和未涵盖的提供者列表。这些清单将定期审查和修订。

[1] 为清楚起见，有资格获得任何形式的保险但不申请或不会申请的个人并非本政策下的合格个人，但前提是符合康涅狄格州公共法案 03-266，任何未投保人（如该法案所定义），不符合资格但收入（不考虑可用资产）低于 FPG 的 250% 的个人将不会被收取超过医院为患者提供服务的成本。

申請流程

除非本政策末尾另有规定，否则只有在提交完整的申请并附有所需文件后才能确定任何经济援助的资格和金额。

1. *申请请求。*可以随时提出经济援助请求。这意味着个人可以在接受服务之前、期间或之后提出请求，包括在针对个人的收款机构行动开始之后。最初的经济援助请求可以以书面形式或通过电话提出。在提出经济援助请求时，个人应被告知本政策并发送申请和摘要的副本。如果个人英语能力有限或不会英语，这些文件将以医院服务社区中英语能力有限的每个重要人群使用的每种语言提供。

2. *申请书的内容。*申请书要求以下的信息：

   A. **以确定申请人：**

      请求日期
      名称
      地址
      电话号码
      提出请求者（如果患者是未成年人，则家长或监护人）
      出生日期
      社会安全号码*

      *如果可提供

   B. **以验证申请人是合格个人：**

      最新可用的一个月期间的工资单
      失业补偿证明
      任何联邦或州福利的证明
      银行账户或投资报表
      经过公证的自我证明作为收入证明

3. *完成申请书。*申请可由符合条件的个人或其法定监护人完成。申请可由符合条件的个人或其法定监护人完成。如果您对填写申请书有任何疑问或需要帮助，请通过以下电话号码和地址联系医院的患者业务服务部。

4. *提交申请书。*申请必须通过以下电话号码和地址提交给患者业务服务部的财务援助助理。

5. *与经济援助助理进行约谈。*在完成申请时或完成并提交申请后，申请人必须

通过以下电话号码与患者业务服务部进行电话筛查或亲自筛查，以进行筛查预约。在完成申请时或完成并提交申请后，申请人必须通过以下电话号码与患者业务服务部进行电话筛查或亲自筛查，以进行筛查约谈。在筛选时，将为每位申请人分配一名财务援助助理，负责处理申请。

6. *如果申请书不完整。*如果医院收到不完整的申请，应在收到后三十(30)天内，通过普通邮件以书面形式将该事实通知申请人，并将其发送至医院为申请人存档的地址。通知应具体说明所需的缺失信息。申请人应至少有三十(30)天的时间来提交缺失的信息，或者可以致电患者业务服务部与指定的财务助理助理讨论任何缺失的信息。

确定经济援助的资格和金额

医院在审核申请时将遵循下列程序。决定将逐案处理，并按照以下规定处理：

1. *资格。*医院将根据申请的内容确定个人是否符合上述保险标准和收入标准，因此是合格个人。

2. *经济援助金额。*假设申请人被确定为合格个人（有资格获得经济援助），医院将确定要提供的援助金额。

   A. **确定符合条件的个人义务的滑动量表。首先，医院应在申请经济援助之前确定合格个人将负责的金额。**这被称为“**合格个人义务**”，如下所示：

      i. 对于未投保的合格个人，合格个人义务是账户总费用。

      ii. 对于保险不足的合格个人，合格个人义务是合格个人的任何免赔额、共付额和共同保险义务的总和。

   B. **确定符合条件的个人义务的折扣。**为符合条件的个人义务提供的折扣将根据以下滑动比例确定；所示折扣将适用于符合条件的个人义务，具体取决于收入水平：

FPG 的 250% 和以下	100% 折扣
FPG 的 251% 至 FPG 的 300%	90% 折扣
FPG 的 301% 至 FPG 的 350%	80% 折扣
FPG 的 351% 至 FPG 的 399%	70% 折扣
FPG 的 400%	60% 折扣

C. **收费金额限制-任何符合条件的个人都不会被收取超过一般收费金额（“AGB”）的费用**。无论以上确定的折扣水平如何，在任何情况下，合格个人的收费都不会超过合格服务的一般计费金额 (“AGB”)。医院使用基于商业健康保险和老人医疗保险（Medicare）费率的“回顾法”每年计算其 AGB。向合格个人收取的净额将通过 (i) 计算向患者提供的服务的总费用，以及 (ii) 应用上述适当的折扣来确定。包含当前 AGB 计算的文件可在医院网站 https://stamfordhealth.org/patients-visitors/fap/ 上获取，并可通过邮件免费取得。您也可以通过发送电子邮件至 CustomerServiceR@stamhealth.org、致电(203)276-7572 联络电客户服务部、传真至(203)276-7093 或亲自前往：患者业务服务，康涅狄格州华盛顿大道1351号7楼，邮编：06902）向我们的客户服务部要求一份当前的AGB计算。AGB计算适用于在医院服务的社区中英语水平有限的每个重要人群使用的每种语言。

3. *决定通知/拒绝上诉。*医院应在收到完整申请后三十(30)天内确定资格和经济援助水平（如有）。如果个人表示他或她更愿意以电子方式接收通知和通信，则医院根据本政策发出的所有书面通知或通信可以通过电子邮件或其他形式的电子通信提供。

   A. **批准通知**。在审核完成的申请并决定提供经济援助后，医院应向符合条件的个人或其法定监护人发送或给予经济援助批准函，以及说明以下信息的 FAP ID 卡：

      确定日期

      患者名字

      患者的医疗记录编号

      有效日期

      适当指定人员的资格认定（批准/拒绝）

      批准的折扣金额

   B. **拒绝通知**。在审查完成的申请并作出决定拒绝经济援助后，医院将向申请人或其法定监护人发送或给予拒绝经济援助信函，说明拒绝的原因。

医院将随完成的申请一起提交通知副本（拒绝或批准）。

4. *上诉流程。*患者可以对拒绝经济援助或提供的经济援助水平提出上诉。患者可以通过致电、发送电子邮件或写信给其指定的财务援助助理，或在患者业务服务部进行面对面约谈来发起上诉。如果患者提出上诉，患者业务服务部工作人员将重新审查该个人的文件，包括任何新提交的材料，并将再次记录其批准或拒绝，并根据本节在提交上诉的三十(30)天内通知患者。

一旦获得最终批准

1. *经济援助的期限。*符合条件的个人应保持如此确定的援助水平的资格（无需采取任何进一步行动），自初步确定之日起一(1)年，或上诉完成后的确定之日，如果提出了上诉。

   尽管有上述规定：

   A. **情况的负面变化。**如果情况发生变化，符合条件的个人认为需要额外的经济援助，符合条件的个人可以在一(1)年内再次申请经济援助，并可能根据政策获得额外的经济援助 ，如果适用。

   B. **情况的积极变化。**预计如果接受经济援助的合格个人情况发生重大变化（例如从无保险状态变为有保险状态）；符合条件的个人将通过下面列出的电话号码通知患者业务服务部，以便作出日后的考虑。这种情况的积极变化不会用于减少任何已经授予的经济援助。为清楚起见，符合条件的个人无需报告情况的微小变化，而必须仅报告那些会明显影响未来经济援助决定的变化。

2. *提供虚假或误导性信息*。如果医院获悉经济援助申请人在申请过程中提供了重大虚假或误导性信息，医院可能会在审查申请或继续获得经济援助的资格时考虑这些信息。

3. *付款计划。*允许使用付款计划来支付符合条件的个人债务。此类计划的最长期限应为 1 年，前提是可以逐案评估例外情况。付款计划不收取利息。

4. *第三方慈善计划。*如果符合条件的个人通过公认的第三方慈善外展计划转介到医院，该计划提供与上述不同的条款和条件，则医院可以参与此类计划，并且本政策将被视为必要的修改。

催款活动

所有医院收款活动都在计费和收款政策中进行了描述和解释。计费和收款政策也可在医院网站 https://stamfordhealth.org/patients-visitors/fap/上获取，并可通过邮件免费获取。如果个人的英语能力有限或不会英语，这些文件将以医院服务社区中英语能力有限的每个重要人群使用的每种语言提供。

报告和合规

医院将向康涅狄格州提交有关该计划的必要报告。

经授权的医院员工对计划决定进行定期审查，以确保遵守本政策和计费和收款政策。

联络信息

如需有关经济援助计划的更多信息或申请经济援助申请，请按以下地址和电话号码联系患者业务服务部，与经济援助助理交谈。如果要求，将提供医院所服务社区中英语水平有限的每个重要人群所说的每种语言的外语翻译。

患者业务服务部

斯坦福医院患者业务服务部
康涅狄格州斯坦福华盛顿大道 1351 号 7 楼，邮编：06920

电话：(203) 276-7572
传真：(203) 276-7093
电邮地址：CustomerServiceR@stamhealth.org

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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.

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.

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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.

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 at any time. 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 from the most current available one-month period
      Proof of unemployment compensation
      Proof of any Federal or State benefits
      Bank account or investment statements
      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 must be submitted to the Financial Assistance Associate in the Patient Business Services Department at the telephone

number and address set forth below.

5. *Appointment with Financial Assistance Associate*. Either while completing or after completion and submission of the Application, the applicant must set up either a phone screening or an in-person screening appointment with the Patient Business Services Department at the telephone number set forth below to set up a screening appointment. At the time of the screening, each applicant will be assigned a Financial Assistance Associate who will be responsible for processing the Application.

6. *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 applied 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. **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 CustomerServiceR@stamhealth.org, by calling Customer Service at (203) 276-7572, by fax at (203) 276-7093 or in person at: Patient Business Services, 1351 Washington Blvd, 7th Floor, 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, along with a FAP ID card indicating the following information:

Date of determination

Patient's name

Patient's medical record number

Effective Date

Eligibility Determination (Approve/Denied) by appropriate designee

Amount approved for discount

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 Hospital Patient Business Services Department
1351Washington Boulevard, 7th Floor
Stamford, Connecticut 06902

Telephone: (203) 276-7572
Fax: (203) 276-7093
Email address: CustomerServiceR@stamhealth.org