Silver Hill Hospital
Financial Assistance Policy

OVERVIEW

Silver Hill Hospital, Inc. offers financial assistance, in the form of reduced rates, to qualifying patients receiving emergency or medically necessary services. The full text version of the Hospital's financial assistance policy is available online at www.silverhillhospital.org or by requesting a free copy from the Hospital's Admissions Department, 208 Valley Rd. New Canaan, CT 06840, Phone (203) 966-3561.

WHO QUALIFIES

This policy applies to patients receiving emergency or medically necessary services that:

- have no insurance, or
- have exhausted their insurance benefits, and
- have income of less than 300% of the Federal Poverty Guidelines (FPG)

Family Size	1	2	3	4	5	6	7	8
300% of FPG	$36,180	$48,720	$61,260	$73,800	$86,340	$98,880	$111,420	$123,960

This policy excludes patients that have insurance but do not wish to use it. Coinsurance, co-payments and deductibles are also excluded from this policy.

FINANCIAL ASSISTANCE

Patients that qualify for financial assistance will be charged no more than amounts generally billed (AGB).

APPLICATION PROCESS

Patients seeking financial assistance for emergency and medically necessary services will be required to complete a Financial Assistance Application, and provide copies of the following:

- Driver's license
- Most recently filed income tax return
- W2's and/or recent pay stub information
- Support for other forms of income

Financial Assistance Applications and instructions are available online at www.silverhilhospital.org, or by requesting a free copy from the Hospital's Admissions Department, 208 Valley Rd. New Canaan, CT 06840, Phone (203) 966-3561.

WHEN TO FILE FOR FINANCIAL ASSISTANCE

Patients may file for financial assistance up to 240 days from the date the Hospital issues its first, post-discharge billing statement.

In the event the Hospital receives an incomplete Financial Assistance Application from the patient, the Hospital will provide the patient with a list of missing documentation or information. The patient has 30 days to submit the missing information.

Purpose:

The purpose of this Financial Assistance Policy is to set forth Silver Hill Hospital's policy for providing Financial Assistance and the conditions under which Financial Assistance is granted.

This Policy is intended to comply with Section 501(r)(4) of the Internal Revenue Code and any regulations promulgated thereunder and must be interpreted and applied in accordance with those laws and regulations.

Scope:

This Policy applies to Emergency Services and Medically Necessary Services rendered to an uninsured patient with income of less than 300% of the Federal Poverty Guidelines.

This policy excludes patients that have insurance but do not wish to use it. Coinsurance, co-payments and deductibles are also excluded from this policy.

This Policy does not apply to services provided by any other providers who bill independently for their services. See Appendix A.

Definitions:

"Eligibility Criteria" means the criteria set forth in this Policy to determine whether a patient qualifies for Financial Assistance for the services provided.

"Emergency Services" means emergency medical services as defined by EMTALA.

"EMTALA" means the Emergency Medical Treatment and Labor Act, 42 USC 1395dd. The essential provisions of the statute are as follows: any patient who "comes to the emergency department" requesting "examination or treatment for a medical condition" must be provided with "an appropriate medical screening examination" to determine if he/she is suffering from an "emergency medical condition". If he/she is, then the hospital is obligated to either provide him/her with treatment until he/she is stable or to transfer him/her to another hospital in conformance with the statute's directives.

"Federal Poverty Level Guidelines" means the federal poverty level guidelines established by the United States Department of Health and Human Services in effect on the date of the provision of the Health Care Service for awards of Financial Assistance under this Policy.

"Financial Assistance" means free or discounted emergency and/or medically necessary care provided to patients who, pursuant to the Eligibility Criteria, have been determined to be eligible for discounted services under this Policy.

"Medically Necessary" means Inpatient Services.

"Patient" means a person receiving or registered to receive medical treatment or in context of the policy refers to the person liable for payment.

"Uninsured" means a patient who has no level of insurance or third party assistance to assist in meeting his or her payment obligations for emergency or medically necessary services, including those with exhausted benefits or benefits termination, and is not covered by Medicare, Medicaid, Tricare, or any other health insurance program of any nation, state, territory or commonwealth, or under any other governmental or privately sponsored health or accident insurance or benefit program including, but not limited to workers' compensation and awards, settlements or judgments arising from claims, suits or proceedings involving motor vehicle accidents or alleged negligence.

Policy:

Emergency and Medically Necessary Services:

Eligibility Criteria - Financial Assistance Guidelines:

Uninsured patients, with income equal to less than 300% of the Federal Poverty Guidelines (see Appendix B), will be charged no more than amounts generally billed (AGB). AGB is calculated using a "look-back" retrospective calculation based upon amounts allowed by Medicare and Commercial insurers. See Appendix C for the most recent information on AGB,

Process for Applying and Determining Eligibility for Financial Assistance:

A patient seeking Financial Assistance for Emergency and Medically Necessary Services will be required to complete a Financial Assistance Application Form and provide a copy of his/her driver's license, most recently filed income tax return, a W2 and/or recent pay stub information, and other applicable documents. A patient seeking Financial Assistance must attest to the fact that he/she is uninsured on the Financial Assistance Application.

Financial Assistance Applications and instructions are available online at www.silverhilhospital.org, or by requesting a free copy from the Hospital's Admissions Department, 208 Valley Rd. New Canaan, CT 06840, Phone (203) 966-3561. Written information regarding the application process for financial assistance will be available in Admissions.

Financial Assistance and Collection Practices:

Patients may file for Financial Assistance up to 240 days from the date Silver Hill Hospital issues its first, post-discharge billing statement.

In the event the Hospital receives an incomplete Financial Assistance Application from the patient, the Hospital will provide the patient with a list of missing documentation or information. The patient has 30 days to submit the missing information.

A copy of the Hospital's Billing and Collections Policy for those that qualify for Financial Assistance is available in Admissions, or by requesting a free copy from the Admissions Department, 208 Valley Rd. New Canaan, CT 06840, Phone (203) 966-3561.

Appendix A – Independent Providers Excluded from Financial Assistance Policy

Anesthesia Associates of Southern Connecticut

Appendix B – Federal Poverty Thresholds for Finance Assistance

Family Size	100%	200%	300%
1	$12,060	$24,120	$36,180
2	$16,240	$32,480	$48,720
3	$20,420	$40,840	$61,260
4	$24,600	$49,200	$73,800
5	$28,780	$57,560	$86,340
6	$32,960	$65,920	$98,880
7	$37,140	$74,280	$111,420
8	$41,320	$82,640	$123,960

Appendix C – Amounts Generally Billed Calculation:

Amounts Generally Billed (AGB) is based on the average of the amounts that were paid to the Hospital by Medicare and Commercial insurers for emergency or medically necessary services. For the period March 1, 2016 through February 28, 2017, total expected payment from allowed claims was divided by total billed charges for such claims, and that number was subtracted from 1 to calculate the AGB percentage. The 2017 AGB reduction to gross charges for emergency and medically necessary services is 31%.

SILVER HILL HOSPITAL
EMERGENCY & MEDICALLY NECESSARY SERVICES
FINANCIAL ASSISTANCE APPLICATION

Patient:	**Guarantor:**
Medical Record #:	Medical Record #:
Date of Birth:	Social Security # (if issued):
Social Security # (if issued):	Home Phone:
Home Phone:	Work Phone:
Work Phone:	Relation to Patient:
Address:	Address:
# of dependents in the household:	# of dependents in the household:
Are you a dependent? Circle Yes or No	Is the patient a dependent? Circle Yes or No
Insurance Name:	Insurance Name:
Policy #:	Policy #:
Occupation & Employer:	Occupation & Employer:

Please provide the following financial information:

	MONTHLY INCOME			
	Salary/Wages	**Self Employment Income, Child Care Income, Alimony, Child Support**	**Unemployment Income, Social Security, Pension Benefits, Worker's Compensation**	**Interest, Dividends, and/or Annuity Payments**
Patient				
Spouse				
Guarantor				

Please attach copies of the following documents, if applicable:

Income Source:	**Proof of Income:**
Salary/Wages	Most recent Federal Income Tax return (signed) and your most two recent pay stubs
Self-Employment Income, Child Care Income, Alimony, Child Support	Most recent Federal Income Tax return (signed)
Unemployment Income, Social Security, Pension Benefits, Worker's Compensation	Most recent Federal Income Tax return (signed) or other proof
Interest, Dividends, and/or Annuity Payments	Most recent Federal Income Tax return (signed) or Statement from financial institution stating the amount and frequency paid year to
If you have no income	A letter from the person who supports you or a letter signed by you explaining your current financial situation.

"I attest that I do not have insurance and request the hospital to make a determination of eligibility for financial assistance. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provide is false, I may be denied financial assistance and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."

Patient's Signature:_____ Date: _____

Hospital Representative's Signature:_____ Date: _____

FOR HOSPITAL USE ONLY

FINANCIAL ASSISTANCE REVIEW

Patient: _____

MR#: _____

Notes: _____

_____

_____

Approved _____ Denied _____

Reason for Denial: _____

_____

Signature: _____ Date: _____

Signature: _____ Date: _____