

Silver Hill Hospital
Financial Assistance Policy for Emergency and Medically Necessary Inpatient Services

OVERVIEW

Silver Hill Hospital, Inc. offers financial assistance, in the form of reduced rates, to qualifying patients receiving emergency or medically necessary services. This financial assistance policy is available online at www.silverhillhospital.org under “Resources& Blog/ Downloads, Forms & Pricing/ Financial Assistance Policy and Application. It may also be obtained by email at shhfinancialassistance@silverhillhospital.org and requesting a copy.

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	\$40,770	\$54,930	\$69,090	\$83,250	\$97,410	\$111,570	\$125,730	\$139,890	add \$14,160 for each additional person

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 the lesser of 120% of Medicare payments (\$1260/day) or the amounts generally billed (AGB), as defined and calculated in Appendix C.

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 and assets

Financial Assistance Applications and instructions are available online at www.silverhillhospital.org or by requesting a free copy from the Hospital’s Patient Accounts Department, 208 Valley Rd. New Canaan, CT 06840, Phone (203) 801-2301.

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.

SILVER HILL HOSPITAL	POLICY NAME: Financial Assistance Policy	
INITIATED BY: Director of Patient Accounts	MANUAL NAME: Patient Accounting	
APPROVED BY: CFO	JCAHO STANDARD:	
Date of Issue: 3/1/2016	Revised Date: January 2023	Page 1 of 5

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 financially supported emergency and/or medically necessary care provided to patients who, pursuant to the Eligibility Criteria, have been determined to be eligible for financially supported 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.

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“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 the lesser of 120% of Medicare payments (\$1260/day) or the amounts generally billed (AGB), as defined and calculated in Appendix C.

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.silverhillhospital.org, or by requesting a free copy from the Hospital’s Patient Accounts Department, 208 Valley Rd. New Canaan, CT 06840, or by email: shhfinancialassistance@silverhillhospital.org.

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 Patient Accounts Department, 208 Valley Rd. New Canaan, CT 06840, Phone (203) 801-5555.

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Date of Issue: 3/1/2016	Revised Date: January 2023	Page 3 of 5

Appendix A – Independent Providers Excluded from Financial Assistance Policy

Anesthesia Providers

Financial Assistance Policy

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Date of Issue: 3/1/2016	Revised Date: January 2023	Page 4 of 5

Appendix B – Federal Poverty Thresholds for Finance Assistance

2023 Federal Income Poverty Guidelines				
<u>Family</u> <u>Size</u>	<u>FPG</u>	<u>100%</u>	<u>200%</u>	<u>300%</u>
1	\$13,590	\$ 13,590	\$ 27,180	\$ 40,770
2	\$18,310	\$ 18,310	\$ 36,620	\$ 54,930
3	\$23,030	\$ 23,030	\$ 46,060	\$ 69,090
4	\$27,750	\$ 27,750	\$ 55,500	\$ 83,250
5	\$32,470	\$ 32,470	\$ 64,940	\$ 97,410
6	\$37,190	\$ 37,190	\$ 74,380	\$ 111,570
7	\$41,910	\$ 41,910	\$ 83,820	\$ 125,730
8	\$46,630	\$ 46,630	\$ 93,260	\$ 139,890
Additional person	\$4,720	\$ 4,720	\$ 9,440	\$ 14,160

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Appendix C – Amounts Generally Billed Calculation:

Amounts Generally Billed (AGB) is based on the average of the contracted rates that are paid to the Hospital by the Behavioral Health insurance companies for emergency or medically necessary services. AGB is calculated by taking the expected payment from allowed claims and dividing by total billed charges for such claims, and that number is subtracted from 1 to calculate the AGB percentage. The AGB for 2021, 2022 and 2023 is \$1299, \$1507, and \$1764, respectively. The average charge/day for 2021, 2022 and 2023 is \$1600, \$2800, and \$2800, respectively. The AGB reduction to gross charges for emergency and medically necessary services is 19% for 2021, 46% for 2022, and 37% for 2023.

**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				

ASSETS

Bank accounts:				
Checking				
Savings				
Investment accounts:				
Retirement accounts:				
	<u>Year acquired</u>	<u>Purchase Price</u>	<u>Market Value</u>	<u>Mortgage/loan</u>
Primary residence				
Vacation property				
Cars				
Boats				
Planes				
Other Real Estate				

"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: _____

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.
Assets	Proof:
Bank Accounts	Most recent bank statement
Investment Accounts	Most recent Investment account Statement
Retirement Accounts	Most recent Retirement account statement
Primary residence	Deed and most recent mortgage statement
Vacation property	Deed and most recent mortgage statement
Cars	Purchase receipt and most recent loan statement
Boats	Purchase receipt and most recent loan statement
Planes	Purchase receipt and most recent loan statement
Other Real Estate	Deed and most recent mortgage statement

<u>2023 Federal Income Poverty Guidelines</u>				
<u>Family Size</u>	<u>FPG</u>	<u>100%</u>	<u>200%</u>	<u>300%</u>
1	\$13,590	\$ 13,590	\$ 27,180	\$ 40,770
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Additional person	\$4,720	\$ 4,720	\$ 9,440	\$ 14,160
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We are able to offer financial assistance to patients with need because of the generous gifts of Silver Hill donors. When your stay at Silver Hill is complete, and if you are satisfied with your treatment program, there is an opportunity for you to play a significant role in ensuring future financial assistance for other patients like yourself. By writing a short "impact statement" describing how your stay at Silver Hill has helped you, you will inspire donors to continue to provide these crucial funds to others in need. Many patients have a desire to "give back" when their stay is completed, and this is a simple and much appreciated way to do just that. Silver Hill staff is available to help you to write a statement should you need any assistance at all. Thank you for being an important part of the cycle of giving.

FINANCIAL ASSISTANCE REVIEW

Patient: _____

MR#: _____

Notes: _____

Approved _____

Denied _____

Reason for Denial: _____

Signature: _____ Date: _____

Signature: _____ Date: _____