Silver Hill Hospital
Transitional Living Program
Financial Assistance Policy

PURPOSE:
To develop clear and concise guidelines for awarding financial assistance to applicants being considered for admission to the Transitional Living Programs. The Professional Program at Steward House and Argent Program at Hill House are not eligible for Patient Financial Assistance.

To ensure objectivity and maximize access for patients who qualify for financial assistance for the Transitional Living Programs.

POLICY:
Silver Hill is committed to providing financial assistance to patients who meet clinical and financial criteria in order to receive treatment in Silver Hill Hospital's Transitional Living Programs. Clinical and financial guidelines have been developed to ensure access to financial assistance for those patients that qualify.

PROCEDURE:
(1) The treatment team is responsible for identifying patients who are clinically appropriate and motivated for treatment in one of the Hospital's Transitional Living Programs.
(2) The treatment team is responsible for speaking with the patient/family to discuss the benefits of longer-term treatment in transitional living and recommend the appropriate program.
(3) With the patient's agreement, the physician or social worker is responsible for communicating the recommendation for admission to the transitional program to Patient Accounts who will discuss financial options, including the availability of financial assistance, with the patient/family.
(4) The Chief Clinical Officer and the Director of Clinical Operations, working with the Program Team Leads, confirms the patient's clinical appropriateness for admission to transitional living and determines bed availability. The patient is required to complete the TLP Financial Assistance Clinical application form to demonstrate desire and motivation, which is reviewed and approved by the Chief Clinical Officer.
(5) Once bed availability has been secured, the patient is required to complete the Transitional Living Financial Assistance Financial Application form and submit a copy of the prior year's W2 form and filed Federal tax return, along with any other documents required on the application form. If the patient is declared as a dependent on another's tax return, the tax return on which the patient is declared as a dependent must be submitted for review. Adjusted gross income as stated on the patient's or family's tax return determines eligibility, subject to a review of assets. Eligibility is based on a multiple of the prior year's Federal Poverty Guidelines which take into account income and family size. Eligibility is also subject to a review of assets.
(6) The patient/family sign a document attesting that the information provided is true and accurate. The attestation form is submitted along with the supporting documentation to Patient Accounts.
(7) Final review and approval of the financial assistance request is performed by the Chief Financial Officer or designee.
(8) Financial assistance awards range from 25% to 90% of program charges for adults and adolescent patients. Prior to the patient's admission to a transitional living program, all patients/families must arrange payment for the cost of the program not covered by financial assistance.

ELIGIBILIITY:

Patients who meet the following eligibility will be given preference for financial assistance:

(1) The patient is a US resident and has continuously maintained residence with the US and its territories for a period of at least 12 consecutive months immediately preceding admission to the Transitional Living Program.
(2) The patient has not previously been a financial assistance recipient.
(3) The patient has recently/is currently receiving inpatient treatment at Silver Hill Hospital.
(4) The patient has been evaluated by the Hospital's clinical team and is determined to be appropriate and motivated for TLP treatment. Note: Professional Program (Steward House) and Evaluation Program (Argent/Hill House) participants are not eligible for financial assistance.
(5) There is an available bed in the program. Available bed = bed that is currently available and not reserved for a scheduled admission.
(6) A patient seeking financial assistance for TLP will be required to complete a Clinical and Financial Assistance Application Form and provide supporting documentation. The Hospital may request additional financial records based on its initial review of the financial assistance application.
(7) For patients aged under 26, when reviewing the Financial Assistance Application, the Hospital will consider debt, living expenses, living with parents or other family members. If it is determined that the patient is living with family members or a dependent of his/her parents or other family member, the Hospital may request the family member(s) tax returns and other financial records.
(8) Financial assistance will NOT be provided for participating in the same or another transitional living program beyond the initial standard length of the program (28, 35 or 42 days depending on the Program). Any other amount of time requires approval by the CFO and should be assessed and approved 72 hours before discharge.
(9) Financial assistance may be provided for a program extension beyond the standard program length if a patient has paid out of pocket for the first 28, 35 or 42 days, depending on the Program or is no longer covered by insurance. Financial assistance for extensions will not be open ended and must be accompanied by a clinical treatment and discharge plan.
(10) TLP financial assistances is subject to availability of funds. It is expected that, on average, two financial assistance awards per month will be made.

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.

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.

2021 Federal Income Poverty Guidelines		Financial Assistance percentage				
		90%	75%	50%	25%	0%
Family Size	FPG	0-500%	500%-700%	800%	900%	> 900%+
1	$12,880	< $ 64,400	$ 90,160	$103,040	$115,920	> $115,921
2	$17,420	< $ 87,100	$ 121,940	$139,360	$156,780	> $156,781
3	$21,960	< $ 109,800	$ 153,720	$175,680	$197,640	> $197,641
4	$26,500	< $ 132,500	$ 185,500	$212,000	$238,500	> $238,501
5	$31,040	< $ 155,200	$ 217,280	$248,320	$279,360	> $279,361
6	$35,580	< $ 177,900	$ 249,060	$284,640	$320,220	> $320,221
7	$40,120	< $ 200,600	$ 280,840	$320,960	$361,080	> $361,081
8	$44,660	< $ 223,300	$ 312,620	$357,280	$401,940	> $401,941
Additional person add:	$4,540	< $22,700	$31,780	$36,320	$40,860	> $40,860

SILVER HILL HOSPITAL RESTORING MENTAL HEALTH SINCE 1931	TRANSITIONAL LIVING PROGRAM FINANCIAL ASSISTANCE APPLICATION	*Place name sticker here*

Why would you like to be considered for financial assistance to attend the Transitional Living Program?

How do you feel that the Transitional Living Program would benefit you?

Briefly describe the challenges that brought you to Silver Hill that you would like treatment for In the Transitional Living Program.

What are your goals for treatment in the Transitional Living Program?

What motivated you to seek treatment?

What skills would you like to learn while residing in the Transitional Living Program?

How would you positively contribute to the group living experience of the Transitional Living Program?

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Patient Signature: Date:

Chief Clinical Officer: Date:

SILVER HILL HOSPITAL
TRANSITIONAL LIVING PROGRAM
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:				
	Year acquired	Purchase Price	Market Value	Mortgage/loan
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
Retiremment 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

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Additional person add:	$4,540	< $22,700	$31,780	$36,320	$40,860	> $40,860

If the patient has insurance which covers any of the stay, any and all co-insurance and deductibles will not be included in the financial assistance award and will be the responsibility of the patient.

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SILVER HILL HOSPITAL
208 Valley Rd.
New Canaan, CT 06840

TLP Financial Assistance Approval Form

TLP Program: ADOL DBT DBT-S PSYCH

Patient Name: _____ Age: _____

Inpatient Program: _____ Insurance: _____

Financials enclosed:

_____

_____

_____

Notes:

_____

_____

_____

Approved _____

[ ] 90% room and board and IOP	[ ] 90% room and board only
[ ] 75% room and board and IOP	[ ] 75% room and board only
[ ] 50% room and board and IOP	[ ] 50% room and board only
[ ] 25% room and board and IOP	[ ] 25% room and board only

Denied _____
Reason for Denial:

_____

_____

Chief Financial Officer name: _____
Signature: _____Date: _____