Western Connecticut
Health Network

Danbury Hospital · New Milford Hospital · Norwalk Hospital

FINANCIAL ASSISTANCE POLICY

Revised: 10/01/18
Effective: 06/01/18

I. POLICY

A. The Western Connecticut Health Network (the “Network”) is a not for profit, tax-exempt entity committed to advancing the health and well-being of those in its communities by providing an integrated high quality and cost effective network of health care services. Consistent with this mission, the Network recognizes its obligation to the communities it serves to provide financial assistance to indigent persons within those communities. For purposes of this Policy, the Network includes Danbury Hospital, Norwalk Hospital (each referred to as “Hospital), and Western Connecticut Medical Group. Services provided by community-based providers are not covered under this Policy.

B. In furtherance of its charitable mission, the Network will provide (i) emergency treatment to any person requiring such care; and (ii) essential, *non-emergent* care to patients who are residents of its primary service areas who meet the conditions and criteria set forth in this Policy, without regard to the patients’ ability to pay for such care. Elective procedures generally will not be considered essential, non-emergent care and will not be eligible for Financial Assistance.

C. The Network will regularly review this Financial Assistance Policy to ensure that at all times it: (i) reflects the philosophy and mission of the Network; (ii) explains the decision processes of who may be eligible for Financial Assistance and in what amounts; and (iii) complies with all applicable state and federal laws, rules, and regulations concerning the provision of financial assistance to indigent patients. In the event that applicable laws, rules or regulations are changed, supplemented or clarified through interpretative guidance, the Network will modify this Policy and its practices accordingly. The Network maintains a separate Financial Policy for Credit & Collections, a free copy of which can be obtained by contacting the Patient Assistance Corporation at (203) 749-2650. The Credit & Collections Policy sets forth the actions that may be taken in the event of non-payment of amounts determined to be patient responsibility under this Policy.

II. ELIGIBILITY AND DETERMINATION OF DISCOUNT

A. Eligibility: A patient will be eligible for Financial Assistance if the patient: (i) resides in the WCHN defined Primary Service Area or Secondary Service Area, (ii) has limited or no health insurance; (iii) applies for but is deemed ineligible for government medical assistance (for example, Medicare or Medicaid); (iv) cooperates with the Network in providing the requested information and financial documentation; and (v) demonstrates "financial need" based on **Exhibit 1**. In addition, a patient may be eligible for Financial Assistance in the event the Network, in its discretion, deems such eligibility appropriate under a patient's unique circumstances (including potential medical hardship). Consideration may be given to the existence of substantial medical debt, and additional documentation regarding assets and living expenses may be requested. For purposes of this Policy, the term "patient" is used with regard to the patient or the applicable payment source for the patient's care (*e.g.*, parent, guardian or other responsible party).

B. Financial Need: A patient will be deemed to have financial need based on the Federal Poverty Levels ("FPG") in effect from time to time. The table below sets forth the income requirements and related financial assistance discount on the charges for Network services rendered. Income includes salaries and wages, legal judgments, unemployment compensation, worker's compensation, dividends, interest checks and other recurrent sources of income.

PATIENT INCOME	DISCOUNT
At or Below 300% of the FPG	100% or Free Care
Between 301% and 350% of the FPG	75% Discount
Between 351% and 400% of the FPG	AGB Discount Amounts. Generally Billed **(% Varies Annually for each Hospital- see Exhibit 1 for Details)**

C. Calculation of Amounts to Be Billed: In no event will a patient who is eligible for financial assistance under this Policy be charged more than the amounts generally billed ("AGB") by each Hospital in the Network for the emergency or medically necessary care, and for less than gross charges for all other medical care. The Network calculates its AGB using the "Look Back Method" based on commercial and Medicare rates. The net amount to be billed to a patient qualifying for financial assistance hereunder will be determined by (i) calculating the gross charges for services rendered

to the patient, and (ii) applying the appropriate discount (as determined pursuant to the above and Exhibit 1). Notwithstanding the foregoing, however:

1. Pursuant to Connecticut Public Act 03-266, any Uninsured (as defined by the Act) Hospital patient whose income (alone, without regard to available assets) falls below **250**% of the FPGs will not be charged more than the Hospital's cost of providing services to the patient.

III. PROCEDURES AND OBLIGATIONS FOR DETERMINING ELIGIBIITY FOR FINANCIAL ASSISTANCE

A. All patients will be informed of the availability of financial assistance pursuant to this Policy. Patients with an anticipated or actual self-pay balance will be referred to the Network's Financial Counseling Department.

B. Because a patient is not eligible under this Policy until s/he has applied for and been deemed ineligible for federal and state governmental assistance programs, the Network's Financial Counseling Department will assist patients in enrolling in federal and state governmental assistance programs, including, but not limited to the Health Care Exchange Programs. Trained financial counselors and other personnel may be contacted at (203) 739-7773 (Danbury Hospital or Western Connecticut Medical Group), (203) 852-3028 (Norwalk Hospital), or (860) 210-5427 (New Milford Hospital campus) for any assistance required in completing the Application for Financial Assistance or with any other materials required by the Network under this Policy.

C. Although the Network will attempt to make an eligibility determination during pre-registration or prior to discharge, this may not be possible, either because the patient does not provide the necessary documentation, or the patient's circumstances change after discharge, or in other circumstances where a given patient's circumstances or needs are identified. **A patient may request consideration at any time, and the Network will evaluate a patient's eligibility under this Policy as requested, up to and including consideration during the collections and judgment phase.** Patients are encouraged to contact the Network's Financial Services Department if their circumstances change or if additional need is identified. The Network's Financial Counselors will review all information provided and relevant circumstances bearing on the need for Financial Assistance, will make a determination of eligibility, and will notify the patient of his/her financial obligations, if any, as set forth below.

D. Administrative Procedure

1. Network staff will immediately forward to the Hospital's financial counselors a copy of the pre-admission record for any patient who has no insurance. Financial counselors will contact the patient to schedule a financial interview as soon as is practicable but ideally before admission for a non-emergent, medically necessary service, and prior to discharge for an emergency admission. For emergency services, the Network will not delay screening or treatment of an emergency medical condition pending this financial interview.

2. To determine whether a patient is eligible for Financial Assistance, the patient will be required to complete the Patient Financial Worksheet (**Exhibit 2**). The Worksheet will be made readily available to patients through methods including (without limitation) posting on the Hospital's website, distribution at the Hospitals' Patient Registration and Admissions areas and the Patient Financial Services offices, and inclusion in the informational binders provided in patient rooms.

3. Patients must return the Worksheet to the financial counselor in the self-addressed stamped envelope provided by the Network within ten (10) days. Failure to timely supply required information will result in denial of a patient's request for provision of Financial Assistance. Patients are obligated to cooperate and provide all information needed in a timely manner. The Network will make reasonable efforts to offer and provide assistance to patients in connection with the completion of the Worksheet. However, if assistance is needed in gathering necessary information or materials requested as part of the Financial Assistance qualifying process, patients are encouraged to contact one of the Networks trained financial counselors at (203) 739-7773 (Danbury Hospital), (203) 852-3028 (Norwalk Hospital), or (860) 210-5427 (New Milford Hospital campus). Financial counselors also are available to assist patients with assessing their financial situations, gathering information requested by the Network, and assisting with similar tasks.

4. As part of the financial interview process, financial counselors will request the following documentation in order to process and validate Financial Assistance applications:

Required Supporting Documentation	Examples of Acceptable Documentation
Confirmation of Annual Income	Most Recent Federal Income Tax Return Last 4 pay stubs Most recent W-2 or 1099 Social Security Award Letter Unemployment Statement Workers Compensation Award Letter
Verification of Social Security Number and/or Date of Birth	Driver's License State Issued Identification Card Social Security Card Birth Certificate Baptismal Certificate Military Discharge Papers School Records
Verification of Residency	Mortgage Statement Rental Agreement/Lease Tax Bill Room & Board Statement Utility Bill Written Verification from Landlord

E. Although the information above is required from patients seeking Financial Assistance, the Network in its discretion may choose not to require some or all documentation depending upon circumstances and the patient's ability to obtain documentation. The Network may rely on documentation received from credit organizations or other outside entities, including the Norwalk Community Health Center, Americares, and Good Samaritans in determining a patient's eligibility for Financial Assistance.

F. Patients have an obligation to provide information reasonably requested by the Network so that the Network can make a determination of a patient's eligibility for Financial Assistance. **If a patient claims s/he has no means to pay but fails to provide the information reasonably requested by the Network, there will be no Financial Assistance extended and normal collection efforts may be pursued in the Network's sole discretion.**

G. Eligibility and Notification Process:

1. Upon receipt of a patient's Patient Financial Worksheet, the Financial Services Department will review the patient's application to determine that it is complete, including all required documentation. If it is not complete, the application will be returned to the patient for completion. If the Network returns an application to a patient as incomplete, the financial counselor will attempt to contact that patient by telephone. If the counselor is able to reach the patient by telephone, they will offer the patient an in-person or telephonic interview to determine such patient's eligibility for Financial Assistance. If the Network is unable to reach the patient by telephone, or if there is no listed telephone number available, the financial counselor will send a letter to the patient that details what is needed and that explains to the patient that it is his/her responsibility to contact the Network's Financial Counseling Department within ten (10) days of receiving the letter. The Network's trained financial counselors will offer to meet with the patient to assist him/her in completing the application so that the Hospital has all of the necessary information to make a determination of the patient's eligibility for Financial Assistance.

2. The Financial Services Department will complete the Financial Assistance Eligibility Determination Form attached as **Exhibit 3**, and will determine the amount the patient owes, if any. The Financial Services Department will inform the patient of his/her eligibility for Financial Assistance, and the amount of such Financial Assistance, within ten (10) business days of the determination.

3. A determination of eligibility under this Policy will be effective for one (1) year. At the end of such time period, patients continuing to require essential medical services will be expected to re-apply or update their prior applications, in order to permit the Network to make a new determination regarding the patient's continuing eligibility for Financial Assistance.

IV. COMMUNICATION

The Network will communicate the availability of Financial Assistance to its patients and the general public through measures that include providing or posting copies of this Policy, summaries thereof (if more conducive to patient understanding), appropriate signage and/or brochures on the Network's website; In the Hospitals' Emergency Departments; In the Patient Registration and Admissions areas; In the Patient Financial Services Departments; In other waiting areas throughout the Hospitals' premises (as

may be reasonably workable and appropriate); In patient informational binders included in patient rooms; and in bills and statements sent to patients.

Pertinent materials will be provided in English, Portuguese, and Spanish, which are the languages appropriate to the communities served by the Network. Other languages will be added as necessary in the event of changes to the Network's patient population. All such materials will include pertinent contact telephone numbers and/or e-mail addresses to permit patients appropriate resources for completion of the Worksheet and answers to any other questions they may have about the Network's Financial Assistance Program.

V. DOCUMENTATION AND RECORDKEEPING

A. The Financial Counseling Department will maintain all documentation of Financial Assistance within the Hospital's Financial Assistance file. The Financial Assistance file will include a cumulative total of Financial Assistance cases, together with supportive documentation. Supportive documentation will include, at a minimum, the following: (i) The number of applicants for free and reduced cost services; (ii) The number of approved applicants; (iii) The total and average charges and costs of the amount of free and reduced cost care provided; (iv) Any other information required by, or necessarily to permit complete and accurate reporting under, applicable federal and state laws (including without limitation CT Public Act 03-266).

B. The Director of Revenue Cycle will review the status of the Financial Assistance program with the Chief Executive Officer, or his/her designee, on a regular basis. The Chief Executive Officer or his/her designee will be responsible for presenting this Financial Assistance Policy to the Board of Directors at least annually. Such presentation will include a detailed statement on what the Network's policy is on Financial Assistance, the impact of this Financial Assistance Policy on Network operations and the level of need and benefits being conferred to the community under the Network's Financial Assistance program.

C. Information about the amount of Financial Assistance extended will be provided in accordance with federal and state laws and regulations on reporting information under the Network's Financial Assistance Policy.

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APPENDIX I

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file and there is a lack of corresponding supporting documentation. However, there is often adequate information provided by the patient or through external sources which could provide sufficient evidence to offer the patient charity care assistance. In the event there is no concrete evidence to support a patient's eligibility for charity care, Western Connecticut Health Network may use outside sources in determining charity care eligibility *presumptively*. Once determined, due to the inherent nature of the presumptive circumstances, the discount that will be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances including:

(1) Homeless or received care from a homeless clinic
(2) Deceased with no spouse and no estate
(3) Approved by the court for Bankruptcy

EXHIBIT 1

FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES

Based on 2018 Federal Poverty Guidelines

Family Size	Federal Poverty Guidelines (2018)	250% - 300 % (or Below) Poverty Guidelines *(100% write-off)*	301% - 350% Poverty Guidelines *(75% write-off)*	351% to 400% Poverty Guidelines ***(AGB Discount)*** *Danbury/New Milford-58.72% Discount. Norwalk 59.07% Discount*
1	$12,140	$30,350 to $36,420	$36,421 to $42,490	$42,491 to $48,560
2	$16,460	$41,150 to $49,380	$49,381 to $57,610	$57,611 to $65,840
3	$20,780	$51,950 to $62,340	$62,341 to $72,730	$72,731 to $83,120
4	$25,100	$62,750 to $75,300	$75,301 to $87,850	$87,851 to $100,400
5	$29,420	$73,550 to $88,260	$88,261 to $102,970	$102,971 to $117,680
6	$33,740	$84,350 to $101,220	$101,221 to $118,090	$118,091 to $134,960
7	$38,060	$95,150 to $114,180	$114,181 to $133,210	$133,211 to $152,240
8	$42,380	$105,950 to $127,140	$127,141 to $148,330	$148,331 to $169,520

**** For *family* units with more than 8 members, add $4,320.00 for each additional member.**

Note: This Exhibit shall be updated from time to time to reflect the most current FPGs issued by the U.S. Department of Health and Human Services.

EXHIBIT 2

PATIENT/PAYMENT SOURCE FINANCIAL WORKSHEET

Patient Name:_________________________________ **Account Number:**______________
Household Size:____________________

1A Calculation of Available Income

Monthly Salary/Pension	________ x 12 ________	
Monthly SSI/VA	________ x 12 ________	
Income Total	________ x 12 ________	(AA)

1B Calculation of Monthly Expenses

Rent	_________________	
Electric	_________________	
Gas	_________________	
Telephone	_________________	
Water	_________________	
Car Payments	_________________	
Credit Cards	_________________	
Insurance	_________________	
Other _____________	_________________	
Food ($100.00 x dependents)	_________________	
Monthly Expense Total	_________________	
Expense Total	__________x 12_________	(BB)

1C Eligible Income for Hospital Bills _________________ **(CC)**
(AA – BB) (if less than 0, enter 1)

1D Estimate Hospital Billing to Patient _________________ **(DD)**

1E Identification of Liquid Assets

Bank Accounts	____________	
Bonds	____________	
Stocks	____________	
CD's	____________	
Mutual Funds	____________	
Liquid Asset Total	_________________	(EE)

1F Total Patient Due Minus Liquid Assets (DD- EE) _________________**(FF)**

1G Eligible Income Minus Patient Due (CC-FF) _________________**(GG)**
Note: If GG is a negative number, than patient will have no financial responsibility.

____

_____ **I attest that the above information is correct.**

_____ **I attest that the Patient/Payment Source is unemployed and cannot provide employment documentation.**

____ ________________________

Signature of Patient/Payment Source **Date**

EXHIBIT 3

FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION FORM

Date: ___________________

Western Connecticut Health Network has conducted an eligibility determination for Financial Assistance for:
Name: _____________________________

Medical Record Number: _______________

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made.

_______ Your request for Financial Assistance has been denied because your income exceeds the threshold set forth in Western Connecticut Health Network's Financial Assistance Guidelines.

_______ Your request for Financial Assistance has been approved for services rendered on_ ______. The entire balance will be treated as free care.

_______ Your request for Financial Assistance has been approved in accordance with the criteria under P.A. 03-266 for services rendered on __________. You will receive a new billing(s) indicating your new reduced balance.

_______ You qualify for a discount on charges consistent with the Network's sliding scale. Please contact the phone number on your new adjusted bill for a payment plan on the balance (if needed).

_______ Your request has been denied for the following reason:
____
____

_______ Other (please described in detail):
____
____

If you have questions about this determination, please contact:

______________________________at (203) _________________, extension ___________.