You May Qualify for Financial Assistance

Financial Assistance helps cover medical bills for patients in the YNHH system who cannot afford to pay.

Who Qualifies?

- Low or no income.
- No or limited health insurance.
- **Non-citizens are welcome to apply.**

Where does it work?

- Yale New Haven Hospital (YNHH) System.
- It does NOT work anywhere else.

What is the Process?

- Fill out a Financial Assistance Program (FAP) Application.
- You can do this yourself, or we can help you at an appointment with HAVEN Free Clinic.
- Provide **Proof of Income**.

How do I provide Proof of Income?

- **If you are paid via check or pay stubs, obtain 2 from within the past 6 months.**
- **OR** If you are paid **via cash**, obtain a letter of support from your **employer**.
  - **The letter of support templates are on the second page.**
- **OR** If you are **unemployed,** obtain a letter of support from **the person who is supporting you.**
- To Send Proof of Income:
  - E-mail pictures: hfc.billing@yale.edu
  - OR come to clinic **in person** to drop off Proof of Income **any Saturday from 8:30 AM - 1:00 PM.**

FOR ANY QUESTIONS, call us at 203-200-0673.

Letter of Support Templates

- *Letter Written by Employer:*

[Letter Head]

[Date]

To whom it may concern,

This letter serves as verification that **[FULL NAME OF PATIENT]** is employed by **[FULL NAME OF EMPLOYER]**. **[FULL NAME OF PATIENT]** performs **[BRIEF JOB DESCRIPTION]** and is paid **[DOLLAR AMOUNT] [weekly/biweekly/monthly]** in cash. If you have questions or require additional information, please feel free to contact me at **[EMPLOYER PHONE NUMBER]**.

Sincerely,

[FULL NAME OF EMPLOYER], [EMPLOYER SIGNATURE]

- *Letter Written by Financial Supporter:*

[ADDRESS OF SUPPORTER]

[Date]

To whom it may concern,

I, **[FULL NAME OF SUPPORTER]**, am the **[RELATIONSHIP TO PATIENT]** of **[FULL NAME OF PATIENT]**. I currently provide financial support to **[FULL NAME OF PATIENT]** in the amount of **[DOLLAR AMOUNT] [weekly/biweekly/monthly]** to provide Food and Shelter to **[FULL NAME OF PATIENT (and FULL NAMES OF CHILDREN, if applicable)]**. I am providing my support because **[DETAILED REASON FOR FINANCIAL SUPPORT].** If you have any questions, I can be reached at **[SUPPORTER PHONE NUMBER]**.

Sincerely,

[FULL NAME OF SUPPORTER], [SUPPORTER SIGNATURE]

Application for Financial Assistance Programs

Yale New Haven Health uses one application for most financial assistance programs. By completing this application, you will be considered for our Free Care and Discounted Care programs and hospital bed funds. For instructions on how to apply for financial assistance, please refer to page 2. If you have any questions about this application, call us at **855-547-4584**.

1. Patient Information:

Last Name _____ First Name _____ Date of Birth _____

Street Address _____ Telephone Number _____

City _____ State _____ Zip Code _____ Medical Record Number (if available) _____

2. Family Information: List your spouse and/or any dependent children living in your household. Do not include non-married partners. If more space is necessary, please attach a separate document.

Name of family member	Relationship to applicant	Date of Birth

3. Financial Information: Include information on all sources of income for you and your spouse. Please remember to attach proof of income to your application. Proof of income is a document that shows how much income your family earns at the time you fill out the application. Refer to the table on page 2 for the types of documents that may be used as proof of income.

Income	**Patient** Enter Amount Circle: Weekly, Biweekly, Monthly	**Spouse** Enter Amount Circle: Weekly, Biweekly, Monthly
Gross Wages/ Earnings (Before Taxes)		
Supported by Other Individual		
Child Support/ Alimony Received		
Disability Benefits		
Pension Benefits		
Rental Income Received		
Self-Employment or Farm Earnings		
Social Security/ SSI Benefits		
Trust Funds/ Inheritance		
Unemployment Benefits		
Workman's Compensation		
TOTAL INCOME		
OTHER		
Liquid Assets (assets that can be exchanged for cash on short notice, without losing value. For example, cash, gold, or marketable securities)		

4. Health Insurance:

Are you covered under any health insurance policy, including Medicare or Medicaid, or coverage from another country? ☐ YES ☐ NO

If **yes**, please enter your insurance information below:

Policy Holder:	**Insurer:**	**Policy No.:**
Policy Holder:	**Insurer:**	**Policy No.:**

4a. Does your employer sponsor a Health Saving Account (HSA) fund to help pay for your medical expenses?
☐ YES ☐ NO

5. Please read carefully before signing:

By signing below, I certify that everything I have stated on this application and any attachment is true.

□ I understand that any incorrect, incomplete, or false information on this form could result in rejection of my application for financial assistance.

□ I give Yale New Haven Health permission to verify any and all information.

□ I give Yale New Haven Health permission to request my credit report.

□ I agree to repay the full amount of my financial assistance award if I receive payment of any kind, including awards from a lawsuit, for the services covered by this application.

□ I agree to inform Yale New Haven Health of any changes that could change my eligibility for financial assistance.

□ I understand that in connection with my application for financial assistance, Yale New Haven Health may need to disclose Protected Health Information (as that term is defined in the HIPAA Privacy Rule, 42 CFR Parts 160 through 164) about me in order to determine my eligibility.

□ I understand that any such disclosure will be for payment purposes, as defined in the HIPAA Privacy Rule.

_____ _____

Signature of person applying or legal guardian Date (MM/DD/YYYY)

_____

Printed name of the person applying or legal guardian

Remember to include proof of income or a letter of support with your financial assistance application.

Mail completed applications to:

Yale New Haven Health
SBO, Attn: Financial Assistance
PO BOX 1403,
New Haven, CT 06505