Financial Assistance Application

We, at Catholic Health, humbly join together to bring Christ's healing mission and the mission of mercy of the Catholic Church, expressed in Catholic health care, to our communities.

☐ MERCY HOSPITAL ☐ GOOD SAMARITAN UNIVERSITY HOSPITAL ☐ ST. CATHERINE OF SIENA HOSPITAL

☐ ST. CHARLES HOSPITAL ☐ ST. FRANCIS HOSPITAL AND HEART CENTER® ☐ ST. JOSEPH HOSPITAL

Date _____

Dear _____

RE: Account Number(s) _____

Catholic Health Hospital Financial Assistance Program is designed to help patients who have received medically necessary services but are uninsured or underinsured. Eligibility for the program is based on current income and is available on a sliding scale to individuals with family incomes less than or equal to 400% of the Federal Poverty Level (FPL). For individuals with income greater than 150% of the FPL, liquid assets will not be considered when determining eligibility for financial assistance. **Please note physician services are excluded from this Program.**

When completing the financial assistance application, please note the following:

- You have thirty (30) days from the date of this letter to complete this application.
- An application is not complete until all applicable documentation is received. Acceptable forms of documentation to support **family income** (patient/guarantor and spouse) include the following:
    - Four (4) most recent pay stubs
    - Copy of Social Security payments that you and/or your spouse receive (benefit award letter or bank statement)
    - Copy of unemployment benefits
    - Copy of workers compensation benefits
    - Other income (e.g., alimony/maintenance, rental income, veterans' benefits)
    - Three (3) most recent bank statements (checking and savings) (all pages)
    - Proof of student status (unofficial transcript or current class schedule)
    - Proof of support assistance from another person (letter from person supporting you if you are not paying rent)
    - Prior year tax return
- Once we receive your completed application, you may disregard any hospital bills/statements until you receive a written notification regarding your financial assistance application. Do not disregard bills/statements related to physician services.
- Applicants for financial assistance are expected to fully cooperate in applying for any public insurance programs that we believe you may be eligible (e.g. Medicaid, Child Health Plus, etc.).

Complete, sign, date and return application, along with supporting documentation to:

Catholic Health
245 Old Country Road
Melville, NY 11747
Attn: Financial Assistance Department
Fax number 631-396-4239

Upon receipt of your completed application and all required documents, your application will be reviewed and our determination will be sent to you in writing within thirty (30) days. If you have any questions feel free to contact us at (631) 465-6321.

Sincerely,

Financial Assistance Representative

PLEASE KEEP A COPY OF WHAT YOU SEND FOR YOURSELF

Applicant/Guarantor Information:

Applicant/Guarantor Name: _____ Applicant/Guarantor Social Security # ____-____-____

House/Apt# and Street Name: _____

City: _____ State: _____ Zip Code: _____

Home Phone # (____)____-____ Cell Phone #: (____)____-____ Work Phone #:(____)____-____

Patient Information:

Patient Name: _____ Patient Social Security # ____-____-____

Date of Birth (MM/DD/YYYY): ____/____/____ Account#s: _____

Please note this approval applies to hospital services only – physician services are excluded

Patient's Relationship to Applicant/Guarantor:

☐ Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Child ☐ Other: _____

Do you have health insurance? ☐ Yes ☐ No If yes, please specify:

Total Family Size: List the dependents who reside in the applicant's house for whom the applicant takes financial responsibility.

Family Size - Number in Household: ____

Check the appropriate box for each dependent

Name	Age	Relationship			
		Spouse/Partner	Parent	Child	Other
1.		☐	☐	☐	☐
2.		☐	☐	☐	☐
3.		☐	☐	☐	☐
4.		☐	☐	☐	☐
5.		☐	☐	☐	☐
6.		☐	☐	☐	☐

Total Gross Monthly Income
(for the last 30 days)

Sources of Income	Applicant/Patient	Spouse/ Live In Partner
Income from wages or self-employment (mark all deposits in bank account)	**$**	**$**
Unemployment compensation	**$**	**$**
Social Security benefits	**$**	**$**
Workers Compensation benefits	**$**	**$**
Disability benefits	**$**	**$**
Pension/IRA/Annuity	**$**	**$**
Income from investments	**$**	**$**
Alimony/Maintenance	**$**	**$**
Rental income	**$**	**$**
Other income, such as government income, veterans' benefits, public assistance, strike benefits (mark deposits in bank account)	**$**	**$**
Total Income	**$**	**$**

Assets:

- Do you rent or own home (primary residence) ☐ **Rent** ☐ **Own**
- Do you own a secondary home ☐ **Yes** ☐ **No**

Bank Accounts:

If you do not have bank accounts, please write in a letter how you pay your monthly expenses – include receipts i.e. money orders, cash payment receipts, etc.

- Checking Account Balance(s) $ _____
- Savings Account Balances(s) $ _____

Total Gross Monthly Expenses
(for the last 30 days)

Sources of Expenses	Applicant/Patient	Spouse/ Live In Partner
Mortgage	**$**	**$**
Rent	**$**	**$**
Child Support	**$**	**$**
Alimony/Maintenance	**$**	**$**
Vehicle Payments	**$**	**$**
Medical Expenses	**$**	**$**
Household Expenses	**$**	**$**
Education Expenses	**$**	**$**
Wage Garnishments	**$**	**$**
Other Expenses (please provide details)	**$**	**$**
Total Expenses	**$**	**$**

Outstanding Medical Expenses (please list) **$** _____

CERTIFICATION BY APPLICANT

I certify to the best of my knowledge that the information and documentation provided is truthful, complete and accurate. I understand that the information which I submit is subject to verification by the appropriate facility and any willful misrepresentation of these facts will make me liable for all hospital charges. I will apply for governmental or private medical assistance for payment of my medical expenses. I understand that it is my responsibility to promptly advise the Hospital of any changes to my income or assets.

_____ _____ / _____ / _____

Applicant Signature/Patient Signature (parent/legal guardian-minor child) **Date** (MM/DD/YYYY)

Please return completed applications with supporting documentation to the providing facility or mail completed applications to:

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Melville, NY 11747
Attn: Financial Assistance Department
Fax number 631-396-4239