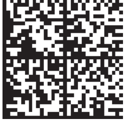

HOSPITAL FINANCIAL ASSISTANCE APPLICATION

Financial Assistance Application - SCAN, HOSPITAL FINANCIAL ASSIST APP, 2/24/25

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 & Heart Center** ☐ **St. Joseph Hospital**

You may be eligible for hospital financial assistance to pay your bills if you are uninsured, if your insurance is exhausted or if you have health insurance but have proof of paid medical expenses totaling more than 10% of your income. Completing this form will start your request for hospital financial assistance. This form is used by all hospitals in New York State.

Account Number(s) ______________________________

Patient Name (complete information that is applicable)

Patient Name (First, Middle, Last)		
Date of Birth (mm/dd/yyyy)		
Address		Apartment/Unit#
City	State	Zip
Contact Phone #		
Parent/Guardian or Lawful Representative Name (if patient is a minor child or an incapacitated adult)		
Email Address (if any)		

Family Information

Please list below all family members in your household. Your household includes yourself, your spouse or domestic partner and any children or other dependents. For example, this would include everyone listed on the same tax return.

Gross income means your income before taxes are deducted. Gross income can consist of work earnings (wages, salaries, tips, earnings from self employment), unearned income (social security, disability and unemployment benefits), contributions (funds from family or friends) and other sources of income (temporary assistance and supplemental security income).

Full Name	Relationship	Total Gross Income (current)
	SELF	

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Full Name	Relationship	Total Gross Income (current)

The hospital may request you submit documentation as proof of income; examples of documentation might include a pay stub, a letter from your employer, if applicable or IRS Form 1040.

Health Insurance Status

Do you have any form of health insurance, including Medicaid, Medicare or private insurance through your employer or purchased on your own? ☐ Yes ☐ No

If you answered "No" would you like assistance in applying for any of these programs? ☐ Yes ☐ No

Underinsured patients: patients with health insurance but have spent more than ten percent (10%) of their gross income on out-of-pocket medical expenses in the past twelve months. If you have insurance, please provide an estimate of the medical bills you paid in the past 12 months.

$

The Hospital may request you submit documentation as proof of paid medical expenses.

Patient Responsible Party

If not the patient, list the name of the person signing the form and their authority to sign on behalf of the patient (e.g., spouse, parent, legal representative).

I understand that the information I submit may be subject to verification from external sources. I certify that the information is true and complete to the best of my knowledge.

Print Name:	Date:
Relationship to Patient:	
Signature:	

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Minimum Eligibility and Guidelines

Application Timeline, Patient Rights and Confidentiality

- You can apply for financial assistance at any point during the collection process.
- You do not have to make any payment to this hospital until you receive a decision on your application for financial assistance. Hospitals may not forward accounts to collection while your application is pending.
- If you are denied financial assistance, you have the right to appeal. Information on how to do so will be included in the hospital's notice you receive. You may have the right to appeal the amount of your financial assistance. The hospital will include information about how to appeal in their decision letter.
- Hospitals cannot send unpaid bills to a collection agency for at least 180 days after your first bill.
- Hospitals are prohibited from taking legal action, including filing lawsuits, to recover unpaid medical bills for patients below 400% of the federal poverty level. Federal poverty guidelines can be found here: https://aspe.hhs.gov/topics/poverty-economic-mobility.
- Any information provided in this application will only be used by the hospital to determine your eligibility for financial assistance and will remain confidential to the extent permitted by law.
- A hospital cannot deny you medically necessary services because you have an outstanding medical bill.
- If you need assistance with this application, please contact Catholic Health's financial assistance department by phone (631) 465-6321 or fax (631) 369-4239.
- If you need additional assistance with this application or help appealing a decision, you can reach out to Community Health Advocates at (888) 614-5400.

Eligibility

The following individuals are eligible for financial assistance:

- Low-income individuals without health insurance; or
- Underinsured individuals (out-of-pocket medical costs paid in the past twelve months amounting to more than ten percent of such individual's gross annual income); or
- Those who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges; or
- At the hospital's discretion, individuals who can demonstrate an inability to pay their copay and/or deductible can request a reduced or discounted payment.
- Please note physician services are excluded from this Program.

Immigration status shall not be an eligibility criterion for the purpose of determining financial assistance.

Catholic Health provides financial assistance to individuals on a sliding scale, up to 100% of charges. Individuals who earn up to 400% of the federal poverty level (FPL) are eligible for financial assistance.

Please refer to Catholic Health's website for its Financial Assistance Income Guidelines and corresponding discounts https://www.catholichealthli.org/paying-your-care/financial-assistance. This schedule is updated annually as the federal poverty guidelines are updated https://aspe.hhs.gov/topics/poverty-economic-mobility.

Minimum Discount Rates

If you qualify for financial assistance, your charges will be reduced according to your income on a sliding scale as follows:

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Income Level	Discount
Below 300% of FPL	Uninsured patients: Waive 100% of charges. Underinsured patients: Waive 100% of the amount that would have been paid pursuant to such patient's insurance cost sharing.
301% – 350 % of FPL	Uninsured patients: Sliding scale up to 90% discount of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 90% discount of the amount that would have been paid pursuant to such patient's insurance cost sharing.
351% – 400% of FPL	Uninsured patients: Sliding scale up to 80% discount of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 80% discount of the amount that would have been paid pursuant to such patient's insurance cost sharing.

Installment Plans

Installment plans are available to patients who are unable to pay the reduced rate all at one time. Monthly payments for patient eligible for financial assistance cannot exceed 5% of your gross monthly income and the rate of interest charged to the patient on the unpaid balance, if any, shall not exceed 2%.

Application Submission

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

Catholic Health
245 Old Country Road
Melville, NY 11747
Attention: Financial Assistance Department
Phone number (631) 465-6321
Fax number (631) 396-4239

Please maintain a copy of your submission for your records.

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Request for Proof of Household Income

Please include the income information for the patient, their spouse and any dependents (such as children). For example, this would include everyone on the same tax return (tax filer, spouse and tax dependents) in the calculation of household income.

The following is a list of documents you can use to prove your income. You do not have to provide all these documents. You can also provide a statement of no household income if you have no income.

You may also provide the Eligibility determination page from the NY State of Health Marketplace. If you have this document, you do not have to provide any other income information listed below to the hospital.

If Household Receives	Amount per Month	Applicant may provide
Wages	$	Please provide one Paycheck Stub, or Letter from Employer on company letterhead, signed and dated, or most recently filed income tax return.
Social Security Payment	$	Copy of award letter/certificate, or correspondence from the U.S. Social Security Administration, or annual benefit letter. To request a copy of your Social Security benefit letter, call 1-800-772-1213 or visit www.ssa.gov
Unemployment Compensation	$	Copy of award letter/certificate or monthly benefit statement from NYS Department of Labor or copy of Direct Payment Card with printout or correspondence from the NYS Department of Labor or printout of recipient's account information from the NYS Department of Labor's website https://dol.ny.gov/
Disability Payment	$	Copy of award letter/certificate or correspondence from Social Security Administration, or copy of annual benefit letter. To request a copy of your benefit letter, call1-800-772-1213 or visit www.ssa.gov
Workers Compensation	$	Copy of Award Letter or Check stub.
Alimony/Child Support	$	Copy of court order, or 3 months of cashed checks/receipts.
Dividends/Interest	$	Quarterly dividend statements or 1 month statements.
Other	$	Letter stating the amount of non-wage earnings (if any), such as rental income, cash for odd jobs, etc.
No Income	$0	Signed statement of no income.

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