Bon Secours Charity Health System

Bon Secours Assistance Program

Guidelines used by Bon Secours Health System, a not-for-profit medical institution

1. All Patients, family members, close friends, associates or the family stating that the patient does not have medical coverage are interviewed, and various options are presented such as Medicaid, straight self pay, contractual pay and/or charity care assistance program.

2. The appropriate signs are conspicuously displayed at the Cashier's window and in the registration area.

3. The attached application must be completed and returned to the Business Office within thirty days, along with a minimum of three proofs of income, copy of previous year's income tax return, and a current copy of all bank account statements.

4. This application is reviewed first by the Centralized Business Office and by the Director of the Business Office, or higher levels of authority, if necessary. The joint review helps to determine whether or not the patient's bill should be discounted in total or in part.

5. During this period of review no bills are sent to the patient or guarantor.

6. A conditional written determination will be made within five working days from the date of receipt of completed application and proof of income.

7. If you disagree with the determination, you can appeal the decision to the next higher level or authority.

PLEASE FILL OUT AND RETURN TO ANN J.

Centralized Business Office
20 Grand Street
Warwick, NY 10990
Tel. 845-987-3908.

Good help to those in need
FINANCIAL DISCLOSURE

Name__________________________  Birthdate__________________________

Address__________________________  Telephone__________________________

Marital Status:  Single_____ Married_____ Divorced_____ Widowed_____

Husband/Wife Name__________________________

I am:  Over 65_____  Blind_____  Permanently Disabled_____

Social Security Number/Railroad retirement Numbers are __________________________

Husband/Wife Social Security Number/Railroad retirement Numbers are __________________________

I am responsible for the support of the following (include yourself):

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<th>Name</th>
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<th>Relationship</th>
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Hospital Insurance

Blue Cross ID#:_________________  Group_______  Policy Holder__________

Medicare #:_________________  Suffix_______

Other Ins. Name__________  Policy Number_________  Policy Holder_________

Insurance Premium Payment $__________________

Home Income (Attach Proof of income)

Social Security $___________  Unemployment Compensation $___________

Veteran Pension $___________  Workmen's Compensation $___________

Railroad Retirement $___________  Union Benefit $___________

Employment $___________  Other $___________

Rent $___________
Employment

Name of Person Employed

Employer

Gross Pay

$ _____ wk_____ mo

$ _____ wk_____ mo

Personal Assets

Cash on Hand/Money in Bank/Savings Acct(s) $ _____ Bank

Checks/bonds/Securities (Cash Value) $ _____

Primary residence (Cash Value) $ _____

Other Real Estate (Cash Value) $ _____

Signature ____________________________ Date ____________________

********************DO NOT WRITE BELOW THIS LINE****************************

Approved ___________ Amount $ ___________ Date ___________

Admission Dates ___________ to ___________

Applicant's Share $ ___________

Approved By ____________________________

Denied ___________ Date ___________

Reason __________________________________

Denied By ____________________________