Required Documentation for Charity Care

The completed *signed* application listing all family members, must be filled out and returned to the Patient Financial Services Department along with the following:

1. Proof of Income for the last *three (3) months*
   Examples are: pay stubs, W-2’s, Social Security checks, unemployment checks.

2. Copy of Income Tax filed for the prior year

3. If you have no Income info, and you are being supported by another person, then a letter is *required* from that party as well as their income info.

4. If applicant is paid in *Cash* – a statement from employer on company letterhead with income info is required.

**NOTE!**
*Without these documents, the Charity Care Application will not be considered! You will be notified by mail of the Hospital’s decision.*

Please return your application to:

Brookhaven Memorial Hospital Medical Center
Patient Financial Services Department
101 Hospital Road
Patchogue, NY 11772
631-654-7130 & 631-654-7140

COMMENTS:


A TRADITION OF CARING
SINCE 1956
Dear Patient and/or Responsible Party:

Brookhaven Memorial Hospital Medical Center provides care to uninsured patients who meet certain criteria under the Hospital Charity Care policy without charge or at amounts less than current established rates. Patient eligibility and the process for submission of an application for this program are explained in this letter.

Patient eligibility for free care is determined by measuring family income against the Income Poverty Guidelines established by the U.S. Department of Health and Human Services. The current requirements are as follows:

<table>
<thead>
<tr>
<th>Size of Family Unit</th>
<th>Two Times the Poverty Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$21,660</td>
</tr>
<tr>
<td>2</td>
<td>$29,140</td>
</tr>
<tr>
<td>3</td>
<td>$36,620</td>
</tr>
<tr>
<td>4</td>
<td>$44,100</td>
</tr>
<tr>
<td>5</td>
<td>$51,580</td>
</tr>
<tr>
<td>6</td>
<td>$59,060</td>
</tr>
<tr>
<td>7</td>
<td>$66,540</td>
</tr>
<tr>
<td>8</td>
<td>$74,020</td>
</tr>
</tbody>
</table>

(For family units with more than 8 members add $3,740 for each additional member).

Patient eligibility for partial charity care will be based on a sliding fee scale when family income exceeds the above stated amounts. Family unit and income are defined using guidelines issued by the Department of Health and Human Services.

If you think you may be eligible for free care or care at reduced rates and wish to request it, please complete the Hospital’s charity care application attached and return it to the Patient Financial Services Department at the address below. Documentation to support the income for all related family members residing at the same address must also be submitted. The Patient Financial Services Department will make a written determination of eligibility after reviewing the application and the information submitted to support the family income reported. If however, based on income and family size, we believe that you may qualify for Medicaid benefits, you may first need to apply for Medicaid or NY State’s Family Health Plus program for the uninsured before a determination will be made under this charity care policy.

If you are returning the application in person, please bring it along with proof of family income to the Hospital Cashier’s office.

Please call the Patient Financial Services Department at (631) 654-7130 or 7140 if you have any questions regarding this process.

RETURN APPLICATION TO: Brookhaven Memorial Hospital Medical Center
101 Hospital Road
Patchogue, New York 11772
Attention: Patient Financial Services Department
Brookhaven Memorial Hospital Medical Center
Charity Care Program Application

Brookhaven Memorial Hospital Medical Center
Patient Financial Services Department
101 Hospital Road, Patchogue, NY 11772
Telephone: (631) 654-7130 & 654-7140

Part A: (to be completed by the Applicant)

Applicant Name: __________________________
Address: _________________________________
Phone #: _________________________________

Date of Application: _______________________
Patient Name: ____________________________
Account #: _______________________________
Date of Service: ___________________________

Family Size: ______________________________
Annual Patient/Family Income:
Salary & Wages: $ _________________________
Other Income: $ ____________________________
Total: $ _________________________________

(MUST ATTACH COPIES OF PROOF OF INCOME)

"I certify that the preceding information is true and correct"

Applicant's Signature (If other than Patient, state Relationship)

Part B: (to be completed by Hospital)

Date Application Received: _______________

DECISION:

( ) Application Approved for Free Care
( ) Application Approved for Financial Assistance – Discount of ______ %
( ) Application Pended ______________________________

( ) Application Denied
Reason: ( ) Income exceeds amount required for eligibility
( ) Other ______________________________

Type of Service: ( ) In-Patient ( ) Out-Patient

Account #: _______________________________
Date of Service: __________________________

Total Charges: $ _________________________
Patient Responsibility: $ ________ **
Charity Care Allowance: $ __________

*If you default on your payment the Financial Assistance rate will not be honored and you will be responsible for total charges.

Hospital Representative Signature - Date

*IF YOU WISH TO APPEAL THIS DECISION PLEASE CONTACT THE CHIEF FINANCIAL OFFICER AT 631-654-7130