ST. JOHN'S EPISCOPAL HOSPITAL

CHARITY CARE &
FINANCIAL ASSISTANCE PROCESS

2009
CHARITY CARE AND FINANCIAL ASSISTANCE PROCESS

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COVER OVERVIEW

SERVICE AREA FOR ST. JOHN'S EPISCOPAL HOSPITAL CHARITY CARE

A. Everyone living in the five boroughs of New York City and Nassau County can get a discount on non-emergency, medically necessary services if they meet the income limits. No one will be denied medically necessary care because they are in need of financial assistance.

B. Everyone in New York State who needs emergency services can receive care and get a discount if they meet the income limits.

C. No charity care will be given for cosmetic surgery admissions.

2009
PATIENT HANDOUT

CHARITY CARE AND FINANCIAL ASSISTANCE PROCESS OVERVIEW

The process to apply for charity care from St. John's Episcopal Hospital is as easy as A-B-C:

As part of our not-for-profit mission, St. John's Episcopal Hospital provides charity care to those who are unable to afford to pay for hospital care. Please contact our Credit & Collections Manager, Patient Accounts Department, or the staff in the department where you seek your care for information about the options available to help with your hospital bill. Confidential information and assistance, including language translation services, are available with advance arrangements.

A. Please arrange to visit with our Financial Counselors in the department where you seek your care

B. Our Financial Counselors will confidentially review your situation to see if you qualify for some form of government or other financial assistance

C. We will confidentially review your income and assets to determine your charity care needs or whether other forms of assistance are available. If you cannot qualify for government assistance and we determine you qualify for charity hospital care, we will provide you with a letter stating that you all or part of your hospital care will be covered

Please Note: St. John's Episcopal Hospital can only provide charity hospital services. You must arrange for other health services (such as physician care, dental care, eyeglasses or prescription drugs) with individual doctors and other non-profit or government agencies for those services.

CHARITY HOSPITAL CARE:
GUIDING PRINCIPLES OF UNDERSTANDING AND RESPONSIBILITIES

St. John's Episcopal Hospital's policy assures that patients receive medically necessary basic hospital services, regardless of their ability to pay. Physicians' services, outpatient medications, and other non-hospital health services are not controlled by St. John's Episcopal Hospital, and therefore, are outside our hospital's policy. It is recognized that St. John's Episcopal Hospital
and other hospitals have limited abilities to absorb rising levels of free and under-reimbursed care. The patient shares a responsibility to work cooperatively with the hospital's billing office, insurers, and government agencies to reimburse the hospital for the services the patient receives. When payment means are not available, the hospital shall inform a qualified patient that his or her bill has been forgiven.

The following points further clarify the principles of understanding regarding the hospital and patients shared responsibilities:

1. Having "no insurance" does not mean the person automatically qualifies for charity care. Similarly, having some level of coverage does not automatically preclude the hospital from writing off some or the entire uncovered portion of patient's bill as charity care.

2. The charity care application process will include an agreement by the applicant to cooperate with the hospital to pursue all appropriate funding options in a timely manner. Based upon a patient's circumstances, the options could include:
   - Medicaid/Medicare/Supplemental Security Income via Social Security Disability
   - Other entitlements
   - Assignments of any hospital services reimbursement received through other sources, lawsuits, etc.
   - Payment plans
   - Charity care (full/partial)

3. The patient will agree to provide accurate information and respond quickly to calls or letters requesting needed information.

4. The charity care application process shall be as streamlined as is feasible while providing a full consideration of income and assets available to cover the bill. Needed assistance will be provided by St. John's Episcopal Hospital to help patients complete any necessary forms. This shall include the assistance of a language translator should the need arise.

5. St. John's Episcopal Hospital's open door policy and charity care application process shall be clearly posted in public areas and in admission materials.

6. Arrangements with physicians for their services are the responsibility of the patient.
Dear Patient:

Thank you for using St. John's Episcopal Hospital. It has been our privilege to be of service. Part of the mission of St. John's Episcopal Hospital is to deliver medical care to all persons in need regardless of their ability to pay.

If you are unable to pay all or part of your hospital bill, our Financial Assistance Office will review your situation to determine if you qualify for government assistance, to establish a monthly payment plan or to determine if you are eligible for Charity Care.

You should come to our Financial Assistance Office located in Room CP156, first floor, during normal business hours (7:30 am to 3:30 pm). You may also call us at 516-349-2902 or speak with the staff in the department where you are seeking care. Please advise the financial counselor if you need an interpreter. Before you come, please complete Section I of the enclosed Application for Financial Assistance form. Even if you cannot come to our Financial Assistance Office, please complete Section I of the Application for Financial Assistance form and return it to the Hospital right away. This information will be used to determine if assistance is available for your Hospital bill. Forms may be obtained at the Registrar's desk in each Hospital service area. You may also request a copy of the form by calling 516-349-2902 and we will mail it to you. The Hospital will process applications for 90 days from date of discharge.

St. John's Episcopal Hospital works hard to provide high quality care and service to our community and beyond. You can be part of our efforts to provide quality care to everyone who comes through our doors by filling out the form and bringing it to the Financial Assistance Office.

Sincerely,

Jonathan Immergut
Chief Financial Officer

HOSPITAL • LONG TERM CARE • PRIMARY CARE
"Healthcare You Can Have Faith In"
Estimado/Estimada paciente:

Gracias por utilizar los servicios de St. John’s Episcopal Hospital. Ha sido para nosotros un privilegio brindarle nuestros servicios. Parte de nuestra misión de St. John’s Episcopal Hospital es brindar atención médica a todas las personas, independientemente de su capacidad de pago.

Si usted no puede pagar la totalidad de su cuenta hospitalaria, o parte de ella, nuestra Oficina de Asistencia Financiera analizará su situación para determinar si cumple las condiciones para recibir asistencia del gobierno, establecer un plan de pago mensual o determinar si es elegible para recibir cuidado catadivo.

Debe presentarse en nuestra Oficina de Asistencia Financiera, ubicada en la Sala CP156 del primer piso, en el horario de atención habitual (de 7:30 a.m. a 3:30 p.m.). También puede llamarnos al 516-349-2902 o hablar con el personal de departamento donde reciba atención. Tenga a bien informar al consejero financiero si necesita los servicios de un intérprete. Antes de presentarse, complete la Sección I del formulario adjunto denominado Solicitud de Asistencia Financiera. Si no puede acercarse a nuestra Oficina de Asistencia Financiera, complete de todos modos la Sección I de la Solicitud de Asistencia Financiera y envíe el formulario completo al hospital de inmediato. Esta información se utilizará para determinar si puede contar con asistencia para pagar su cuenta del hospital. Puede conseguir los formularios en el sector de admisiones de cada área de servicio del hospital. También puede solicitar una copia del formulario llamando al 516-349-2902; le enviaremos la copia por correo. El hospital procesará las solicitudes correspondientes a un plazo de 90 días contados a partir de la fecha de alta.

St. John’s Episcopal Hospital se esfuerza por brindar atención y servicios de excelente calidad a nuestra comunidad y a todas las personas. Usted puede sumarse a nuestros esfuerzos de brindar atención de calidad a todas las personas que atraviesan nuestras puertas si completa el formulario y lo entrega en la Oficina de Asistencia Financiera.

Atentamente,

Jonathan Immordino
Chief Financial Officer

"Healthcare You Can Have Faith In"
CHARITY CARE OR FREE CARE POLICY PROCEDURE

General Guidelines:

Charity Care or Free Care is medical care provided to low income, uninsured, or under-insured people by a hospital or other provider for which it does not expect to be paid.

St. John's Episcopal Hospital uses a consistent process to consider an individual's need for Charity Care based upon each patient's demonstration of inability to pay for their services or have their services covered by another payment source.

General guidelines are utilized which take into account a person's current outstanding and/or anticipated expenses for routine medical services at St. John's Episcopal Hospital, as well as the total service that the patient may require and the patient's potential resources that could be applied towards reimbursement for services.

St. John's Episcopal Hospital will assist patients in making a determination regarding whether or not the patient may be able to qualify for some form of entitlement through a governmental program. St. John's Episcopal Hospital will need the patient to assist in this determination and potential application process.

The application for Charity Care is not and cannot serve as a substitute for existing government entitlement or other assistance programs. When it is determined that the patient has minimal resources and cannot qualify for assistance from any of the entitlement program, either 100% or partial charity will be granted. However, in the event that an individual has significant assets, the hospital may secure its interest in those assets as appropriate. Any coinsurance or deductible amount of $200 or less will not be considered as charity care.

While it is desirable to determine the amount of charity care for which a patient is eligible as close to the time of service as possible, there will be a limit in the time when the determination is made. This time limit will be 90 days from date of discharge.
CRITERIA FOR DETERMINATION OF THE CHARITY AMOUNT

The criteria for determining the amount of charity care for which a patient is eligible at the time of an occasion or service should include the following factors:

1. Individual or family income
2. Individual or family net worth
3. Employment status
4. Family size
5. Other financial obligations
6. The amount and frequency of bills for health care
7. Other sources of payment for the services rendered
PROCESS OF THE CHARITY APPLICATION

1. Staff will work with individuals, face to face or by letter, to gather the necessary information.

2. The applicant's eligibility for government assistance or entitlement programs will be reviewed; i.e., medical assistance (Medicaid/CHCEP) (Catastrophic Health Care Emergency Program)

3. The income chart contained in this guideline, disposable income computations, and the availability of other assets will all be used to help determine if the person qualifies for charity.

4. Charity care decisions will be overseen by the Director of Patient Accounts to ensure, in so far as possible, consistency and continuity.

5. Generally, within 30 days of receipt of all necessary information, the Hospital will inform the applicant of any options that may exist for government assistance, payment plans, or charity care allowance. Once these options no longer exist, the Hospital will inform the applicant via letter or phone call of its charity decision.
INCOME GUIDELINES

In order to provide free care to individuals with income below 300% (FPG) of the federal poverty guidelines, the Hospital refers to the Base on Federal Poverty Guidelines (FPG) effective for the current year FPG change.

- For individuals having an income below 300% (FPG) of the federal poverty and is a household meeting the federal poverty guidelines, they may qualify to have their bill written off as charity when:
  - They are not able to qualify for any other assistance
  - They have cooperated in attempting to qualify, and
  - They do not have other resources to cover the bill
INFORMATION USED TO EVALUATE DETERMINATION OF CHARITY

In order to fairly administer these guidelines, applicants will be asked to provide and fill out the attached form, Statement of Income and Expenses, and St. John's Episcopal Hospital will verify (when necessary) the following information:

- Types of services received or anticipated (i.e., is it a chronic condition that may qualify for other forms of government assistance or other significant expenses anticipated?)
- What is the family size?
- What is the gross monthly income of the household and from what sources?
- What are the reasonable monthly expenses of the household?
- What kind of other resources/assets does the household have?
- **Coinsurance and deductibles of $200 or less will not be considered for charity care.**
- Can the patient qualify for one of the assistance programs available in the community? (coverage considered will include, but not be limited to, Medicaid, Medicaid via SSI, County Assistance, CHCEP Program)
OTHER ASSETS/RESOURCES

In considering other assets or resources which an individual might be able to apply to pay their bill, a review of the patient’s assets will be conducted. However, St. John’s Episcopal Hospital will not consider that the following assets/resources be liquidated in order to qualify for charity care. For patients with income levels of 150% or lower of the federal poverty guidelines, we will consider assets on a case-by-case basis.

The following asset categories will always be exempt:

- Federally qualified personal retirement funds of less than $50,000
- Sole residence
- Automobile(s) required to maintain family income
- Savings or similar assets (i.e.; CDs, stocks, etc.) with a value of less than two months of federal poverty guideline income
### Poverty Level 300% Income Test

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Group I Federal Poverty 100% Clinic Fee Scale (A)</th>
<th>Group II Federal Poverty 150% Clinic Fee Scale (B)</th>
<th>Group III Federal Poverty 200% Clinic Fee Scale (C)</th>
<th>Group IV Federal Poverty 250% Clinic Fee Scale (D)</th>
<th>Group V Federal Poverty 300% Clinic Fee Scale (E)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>up to $10,830</td>
<td>$10,830-$16,245</td>
<td>$16,245-$21,660</td>
<td>$21,660-$27,075</td>
<td>$27,075-$32,490</td>
</tr>
<tr>
<td>2</td>
<td>up to $14,670</td>
<td>$14,570-$21,655</td>
<td>$21,550-$29,140</td>
<td>$29,140-$36,425</td>
<td>$36,425-$43,710</td>
</tr>
<tr>
<td>3</td>
<td>up to $18,310</td>
<td>$16,310-$27,465</td>
<td>$27,465-$36,620</td>
<td>$36,620-$45,775</td>
<td>$45,775-$54,930</td>
</tr>
<tr>
<td>4</td>
<td>up to $22,050</td>
<td>$22,050-$33,075</td>
<td>$33,075-$44,100</td>
<td>$44,100-$55,125</td>
<td>$55,125-$66,150</td>
</tr>
<tr>
<td>5</td>
<td>up to $25,790</td>
<td>$25,790-$38,685</td>
<td>$38,685-$51,560</td>
<td>$51,560-$64,475</td>
<td>$64,475-$77,370</td>
</tr>
<tr>
<td>6</td>
<td>up to $29,530</td>
<td>$29,530-$44,285</td>
<td>$44,295-$59,060</td>
<td>$59,060-$73,825</td>
<td>$73,825-$88,690</td>
</tr>
<tr>
<td>7</td>
<td>up to $33,270</td>
<td>$33,270-$49,905</td>
<td>$49,905-$65,540</td>
<td>$65,540-$83,175</td>
<td>$83,175-$99,810</td>
</tr>
<tr>
<td>8</td>
<td>up to $37,010</td>
<td>$37,010-$55,510</td>
<td>$55,510-$74,020</td>
<td>$74,020-$92,525</td>
<td>$92,525-$111,030</td>
</tr>
<tr>
<td>For each additional person</td>
<td>$3,740</td>
<td>$5,610</td>
<td>$7,480</td>
<td>$9,350</td>
<td>$11,220</td>
</tr>
<tr>
<td>IPASU</td>
<td>patient pays $150</td>
<td>90% write-off patient pays 10% of charges up to Medicaid DRG/PAS Rate</td>
<td>80% write-off patient pays 20% of charges up to Medicaid DRG/PAS Rate</td>
<td>70% write-off patient pays 30% of charges up to Medicaid DRG/PAS Rate</td>
<td>50% write-off patient pays 50% of charges up to DRG/PAS Rate</td>
</tr>
<tr>
<td>Clinio</td>
<td>patient pays $15</td>
<td>patient pays $25</td>
<td>patient pays $35</td>
<td>patient pays $50</td>
<td>patient pays $65</td>
</tr>
<tr>
<td>Lab X-Ray</td>
<td>patient pays 20% of posted charges up to $15</td>
<td>patient pays 30% of posted charges up to $25</td>
<td>patient pays 40% of posted charges up to $35</td>
<td>patient pays 50% of posted charges up to $50</td>
<td>patient pays 70% of posted charges up to $65</td>
</tr>
<tr>
<td>Rehab Other Ancillary Tests</td>
<td>no charge patient pays $0</td>
<td>patient pays $25</td>
<td>patient pays $35</td>
<td>patient pay $50</td>
<td>patient pays $65</td>
</tr>
<tr>
<td>Prenatal Clinic and Pediatric ER/Clinic</td>
<td>patient pays $15</td>
<td>patient pays $25</td>
<td>patient pays $35</td>
<td>patient pays $50</td>
<td>patient pays $65</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>patient pays 30% of posted charges up to Medicaid Rate of $125</td>
<td>patient pays 40% of posted charges up to Medicaid Rate of $125</td>
<td>patient pays 50% of posted charges up to Medicaid Rate of $125</td>
<td>patient pays 70% of posted charges up to Medicaid Rate of $125</td>
<td>patient pays 70% of posted charges up to Medicaid Rate of $125</td>
</tr>
</tbody>
</table>

*Effective for dates of service starting January 1, 2009*
Dear Sir/Madam:

As per your request, attached is the form to be completed for a charity care consideration. Please be sure to complete all questions on this form and return it to us as soon as possible for management’s review.

Return To:

St. John’s Episcopal Hospital
Charity Care Consideration Department
700 Hicksville Road, Suite 210
Bethpage, New York 11714

Thank you.

Sincerely,

[Signature]

Credit and Collections Manager
Fecha:

FECHA DE INGRESO O SERVICIO: ______________________________________
Nº DE CUENTA: ______________________________________________________

Estimado señor o señora:

De acuerdo con su solicitud, adjunto encontrará el formulario que debe llenar para consideración de atención de beneficiencia. Asegúrese de responder todas las preguntas de este formulario y devuélvanoslo lo más pronto posible para la evaluación de la administración.

Devuélvalo a:

St. John’s Episcopal Hospital
Charity Care Consideration Department
700 Hicksville Road, Suite 210
Bethpage, New York 11714

Gracias.

Atentamente,

Gerente de Crédito y Cobranzas
## APPLICATION FOR FINANCIAL ASSISTANCE

**NAME:**

**ADDRESS:**

- **NUMBER AND STREET:**
- **CITY:**
- **STATE:**
- **ZIP CODE:**

**TELEPHONE NO.:**

**SOCIAL SECURITY NO.:**

**OCCUPATION:**

**RATE OF PAY:**

**EMPLOYER:**

**ADDRESS:**

**HOSPITAL INSURANCE:**

**POLICY NO.:**

**NAME OF INSURANCE CO/GROUP PLAN**

<table>
<thead>
<tr>
<th>DATE OF SERVICE</th>
<th>TYPES &amp; FREQUENCY OF SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INCOME LIST:**

<table>
<thead>
<tr>
<th>COMBINED INCOME FOR YOURSELF, SPOUSE AND OTHER DEPENDENTS FROM:</th>
<th>TOTAL FOR LAST 3 MONTHS</th>
<th>TOTAL FOR LAST 12 MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WAGES</strong></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>FARM OR SELF EMPLOYMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PUBLIC ASSISTANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UNEMPLOYMENT/WORKERS' COMP.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STRIKE BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ALIMONY/MAINTENANCE</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>CHILD SUPPORT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MILITARY FAMILY ALLOTMENTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PENSIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>INCOME FROM DIVIDENDS, INTEREST, PROPERTY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL INCOME</strong></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

**FAMILY SIZE/NUMBER IN HOUSEHOLD:**

I affirm that the above information is true, complete and correct to the best of my knowledge.

**Signed:**

**Date:**

If you have questions or need help completing this application, call Novitene Watson at (516)340-2902.

If you have received a bill or bills from the hospital, check here ☐

You do not have to make any payment to the hospital until the hospital sends you a letter with its decision on your application.

**LIVING EXPENSES:**

<table>
<thead>
<tr>
<th>RENT OR MORTGAGE</th>
<th>FOOD</th>
<th>TOTAL EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
</tr>
<tr>
<td>TELEPHONE</td>
<td>MISCELLANEOUS</td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
</tr>
<tr>
<td>GAS &amp; ELECTRIC</td>
<td>LIFE INSURANCE</td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
</tr>
<tr>
<td>WATER</td>
<td>INCOME</td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
</tr>
<tr>
<td>CAR (YEAR ___)</td>
<td>EXPENSES</td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
</tr>
<tr>
<td>GAS</td>
<td>DIFFERENCES</td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
</tr>
<tr>
<td>INSURANCE</td>
<td>CHURCH: CARE RATE</td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>PER MONTH</strong></td>
<td><strong>PER YEAR</strong></td>
<td><strong>PER MONTH</strong></td>
</tr>
<tr>
<td>CAR FARE</td>
<td>TOTAL EXPENSES</td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
<td><strong>PER MONTH</strong></td>
</tr>
</tbody>
</table>

2009
INFORMATION USED TO EVALUATE DETERMINATION OF CHARITY CARE

In order to fairly administer Charity Care guidelines, applicants will be asked to provide and fill out the attached form. St. John's Episcopal Hospital will verify (when necessary) the following information:

- Types of services received or anticipated (i.e., is it a chronic condition that may qualify for other forms of government assistance or other significant expenses anticipated?)
- What is the family size?
- What is the gross monthly income of the household and from what sources?
- What are the reasonable monthly expenses of the household?
- What kind of other resources/assets does the household have?
- **Coinsurance and deductibles of $200 or less will not be considered for charity care.**
- Can the patient qualify for one of the assistance programs available in the community? (Coverage considered will include, but not be limited to, Medicaid, Medicaid via SSI, County Assistance, CHCEP Program)

DOCUMENTATION REQUIRED FOR PROOF OF INCOME

Please submit one of the following documents to be reviewed for possible charity care:

- Income tax return, or if no return filed, letter from employer verifying income for last four (4) pay periods.
- Unemployment insurance stubs.
- Support payments—divorce or separation.
- Retirement benefits, workers’ compensation, pension.
- Letter of support from responsible party, with income documentation

Please be sure to complete all questions on both sides of this form and return it to us as soon as possible for management’s review as follows:

St. John’s Episcopal Hospital
Charity Care Consideration Department
700 Hicksville Road, Suite 210
Bethpage, New York 11714
Attention: Novleteen Watson
(516)349-2902

2009
INFORMACIÓN USADA PARA EVALUAR LA DETERMINACIÓN DE ATENCIÓN DE BENEFICENCIA

Con el propósito de administrar de manera justa las pautas de atención de beneficencia, se pide a los solicitantes proporcionar y llenar el formulario adjunto. St. John’s Episcopal Hospital verificará (cuando sea necesario) la siguiente información:

- Tipo de servicios recibidos o previstos (es decir, ¿es una enfermedad crónica que podría calificar para otras formas de ayuda gubernamental o se prevén otros gastos importantes?
- ¿Cuántos integrantes tiene la familia?
- ¿Cuál es el ingreso bruto mensual de los integrantes de la familia y cuáles son sus fuentes?
- ¿Cuáles son los gastos mensuales razonables de los integrantes de la familia?
- ¿Qué otra clase de recursos o activos tienen los integrantes de la familia?
- El coaseguro o deducible de $200 o inferior no se considerará para atención de beneficencia.
- ¿Puede el paciente cumplir con los requisitos para alguno de los programas de ayuda que cuenta la comunidad? (la cobertura considerada incluye, entre otros, Medicaid, Medicare mediante el Ingreso suplementario del Seguro Social (SSI, por sus siglas en inglés), ayuda del condado, Programa de Gastos de Atención de Salud Catastrófica (CHCEP, por sus siglas en inglés).

DOCUMENTACIÓN EXIGIDA COMO COMPROBANTE DE INGRESO

Envíe uno de los siguientes documentos que se revisarán para una posible atención de beneficencia.

☐ Declaración de impuestos, o de no haberla presentado, carta del empleador que compruebe el ingreso de los últimos cuatro (4) períodos de pago.
☐ Talón de pago del seguro de desempleo.
☐ Pagos de manutención – divorcio o separación
☐ Beneficios de jubilación, indemnización por accidentes y enfermedades laborales, pensión.
☐ Carta de respaldo de la parte responsable, con documentación de ingresos.

Asegúrese de responder todas las preguntas en ambas caras de este formulario y devuélvanoslo lo más pronto posible para la evaluación de la administración como se indica a continuación:

St. John’s Episcopal Hospital
Charity Care Consideration Department
700 Hicksville Road, Suite 210
Bethpage, New York 11714
Attention: Novetteen Watson
(516)349-2902