Dear Patient and/or Responsible Party:

Pursuant to Article II(a) of the Bylaws of South Nassau Communities Hospital, the Hospital provides care without regard to source of payment. To this end, the Hospital provides care to uninsured and underinsured patients who meet certain criteria under its charity care policy without charge or at amounts less than it's established Rates. Patient eligibility and the process to apply for this program are explained in this letter.

Note: This charity care program does not cover Physicians whose billing is independent of the hospital.

Patient eligibility for free care or partial charity care is determined by measuring family income and liquid assets against the Income Poverty Guidelines established by the U.S. Department of Health and Human Services according to the table below:

If you think that you may qualify for free care or care at reduced rates and wish to be considered, please complete the attached charity care application and return it to the Financial Assistance Department at the address listed on the application form. Documentation to support the income for all household members residing at the same address must also be submitted. Patient will be given one hundred thirty (130) days from the date of discharge or for recurring outpatients, one hundred thirty (130) days from the end of the month in which service was received, to apply for assistance. A completed application must be submitted to the hospital within thirty days (30) of the request. Upon receipt of a completed charity care application, the hospital shall cease its billing process until a final determination is made.

The hospital will utilize your current income and make a written determination of eligibility within thirty days (30) of receiving and reviewing the completed application and the information submitted to support the household income reported. If based on income and family size, it is determined that you may qualify for Medicaid benefits, New York State's Family Health Plus or other similar programs, the hospital may require you to cooperate in applying for such coverage as a condition of receiving financial aid.

You may disregard any bills sent by the hospital until a written decision is made.

Charity Care is not an insurance coverage. It is a courtesy provided by South Nassau Communities Hospital and it is only valid at South Nassau Communities Hospital.
Required Documentation for Determination of Charity Care Eligibility

The completed, signed application listing all household members must be filled out and returned to the Financial Assistance Department along with the following:

1. **Valid Photo Identification along with proof of address.**
   Examples are: Current utility bill or property tax bill.

2. **Proof of Income for the last 3 months and 12 months.**
   Examples are: pay stubs, W'2's, Social Security checks, unemployment checks.

3. **Copy of filed Income Tax Return for the prior year.**

4. **If you do not have any income information, and another person is supporting you, a letter is required from that party as well as all information listed above.**

5. **If applicant's salary is paid in cash - A statement from the employer on the company's letterhead with income information is required.**

**NOTE:** Applications submitted without supporting documents will not be considered. You will be notified by mail of the Hospital's decision within thirty days (30).

Please return your application to:

South Nassau Communities Hospital
Financial Assistance Department
One Healthy Way
Oceanside, New York 11572
(516) 632-4015

**COMMENTS:**

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APPLICATION FOR CHARITY CARE

Date of Application ____________________________ Hospital Account # ____________________________

Patient’s Name ____________________________ Applicant’s Name ____________________________

Address ____________________________________________________________

Number and Street __________________________ City __________________________ State ______ Zip Code __________

Telephone # __________________________ Employer Name & Telephone # __________________________

Income: List combined income for yourself, spouse and other dependents from:

Wages ........................................... $ __________________________ Total-last 3 months $ __________________________

Self Employment Earnings ...................... $ __________________________

Public Assistance .............................. $ __________________________

Social Security ................................ $ __________________________

Unemployment/Worker's Comp ............... $ __________________________

Alimony ........................................ $ __________________________

Child Support ................................ $ __________________________

Military Family Allotments ................. $ __________________________

Pensions ...................................... $ __________________________

Income From Dividends, Interest, Rent $ __________________________

As a condition to providing Charity Care, you are required to submit proof of income/resources: (1) income tax returns including W-2’s for the past year, (2) pay stubs, Social Security checks, Unemployment or Compensation papers for the past 3 consecutive months 3) other proof as request. Proof means copies.

Family Size: Family members living in your household

Name __________________________ Age ______ Relationship ____________

__________________________________________ ____________________________________________

If additional space is needed, please attach another sheet.

I hereby request that South Nassau Communities Hospital make a written determination of my eligibility for Charity Care. I understand that the information, which I submit concerning my annual income and family size is subject to verification by the hospital and that Charity Care, is offered at the discretion of the hospital. I also understand that if the information, which I submit is determined to be false, such determination will result in a denial and that I will be liable for charges for services provided.

I affirm that the above information is true and correct to the best of my knowledge. Further, I hereby give my permission to South Nassau Communities Hospital to verify any information contained above.

Date: __________________________ Signature of Applicant _______________