POLICY

It is the policy of Westchester Medical Center (WMC) to provide Charity Care in compliance with New York State laws and regulations.

PURPOSE

Westchester Medical Center (WMC), a non-for-profit healthcare organization, is devoted to continued excellence in patient care and serving the community. As a partner in the community, WMC recognizes that it is often necessary to provide care to patients without charge or at amounts less than its established rates while assuring that the long term viability of the hospital is not threatened.

SCOPE

This policy applies to all WMC employees, contractors (including collection agencies), medical staff, and residents.

DEFINITIONS

1. The primary service area of Westchester Medical Center is defined as the five counties of Westchester, Putnam, Orange, Rockland and Bronx. However, Westchester Medical Center will extend its charity care policy to all residents of New York State.
2. "Charity Care" means inpatient and outpatient medically necessary treatment and diagnostic services for uninsured or underinsured patients who cannot afford to pay for the care according to established hospital guidelines. Such treatment is provided by Westchester Medical Center with the expectation that total payment may not be received. Charity Care does not include bad debt or contractual allowances / shortfalls from government or other programs.
3. "Uninsured Patient" means a patient who lacks any medical insurance coverage or a patient who has exhausted his / her medical coverage.
4. "Underinsured Patient" means a patient who has some form of health insurance coverage but has a significant self-pay responsibility which they can not afford to pay.
5. "Co-pays and deductibles" mean the required out-of-pocket self-pay responsibility under the terms of a patient's insurance or government sponsored medical coverage policy.
6. "Bad Debt" is defined as expenses resulting from treatment for services provided to a patient and / or his or her guarantor who, having the requisite financial resources to pay for health care services, has demonstrated by his / her actions an unwillingness to comply with the contractual arrangements to resolve a bill.

7. "Medically Necessary Services" shall mean health care services for the purpose of evaluating, diagnosing, or treating an illness, injury, or disease in accordance with Generally Accepted Standards of Medical Practice. The charity care program is limited to medically necessary services and excludes elective cosmetic procedures. There are no limits on financial assistance based on the medical condition of the applicant.

POLICY AUTHOR

Patient Financial Services / Patient Accounting
Extension 2870 or 2089

RELATED POLICIES

PA16 – Outpatient Credit and Collection
PA17 – Collection Agency Outpatient Policies
PA23 – Self Pay Patients – Discounts and Write Offs
PA24 – Uninsured and Managed Care Patients
PA26 – Fee Scale Patients
PA39 – Fee Scale – Outpatient Clinics
PA51 – Self Pay Contracts – Inpatient and Outpatient Type “T”

PROCEDURE

A. Non-discrimination

Westchester Medical Center shall render medically necessary services to all members of the community, as defined in paragraph three (3) above, who are in need of medical care regardless of the ability of the patient to pay for such services. The determination of full or partial charity care will be based on the patient’s ability to pay and will not be abridged on the basis of age, sex, race, creed, disability, sexual orientation or national origin.

B. Confidentiality

The need for Charity Care may be a sensitive and deeply personal issue for recipients. Confidentiality of information and preservation of individual dignity shall be maintained for all who seek charitable services. Orientation of staff and the selection of personnel who will implement this policy and procedure will be guided by these values. No information obtained in the patient’s charity care
application will be released unless the patient gives express permission, in writing, for such release.

C. Eligibility for Charity Care

a. All available medically necessary health care services, including inpatient, outpatient and clinic services, shall be available to the patients under this policy.

b. The determination of eligibility for charity care will be made upon receipt of a completed application from the patient or authorized representative. Generally, a patient is presumptively eligible for some form of financial assistance if his or her income level is below 500% of the federal poverty level and he/she follows the procedures outlined in this policy to request assistance.

c. The hospital will only consider income levels when determining eligibility for charity care. Personal or family assets, including a primary residence, tax deferred or other comparable retirement account savings, college account savings, or cars will not be taken into consideration.

d. WMC will make a determination of eligibility for charity care based upon income levels provided during the application process. Qualification for the charity care program is based solely on the patient's monthly or annual income in relation to the federal poverty guidelines (see appendix "B").

e. Charity care discounts will be applied based on the guidelines listed in table 7.6 below. The poverty guidelines in this table and in appendix "B" apply to all services except for clinics which have a separate, flat-rate structure detailed below in paragraph E.

(continued on next page)
D. Table of Charity Care Tiers Based on Income Levels (excluding clinics)

<table>
<thead>
<tr>
<th>Charity Care Tier</th>
<th>Family Income as % Federal Poverty Level</th>
<th>Outpatient Discount of Billed Charges</th>
<th>Inpatient Discount of Billed Charges</th>
<th>Plan Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I Free</td>
<td>&lt;=250 %</td>
<td>100%</td>
<td>100%</td>
<td>P11</td>
</tr>
<tr>
<td>Level II Discounted</td>
<td>251% - 350% (but no greater than the outpatient Medicare allowable rates)</td>
<td>60%</td>
<td>60% (but no greater than the inpatient Medicare allowable rates)</td>
<td>P12</td>
</tr>
<tr>
<td>Level III Discounted</td>
<td>351% - 500%</td>
<td>30%</td>
<td>30%</td>
<td>P13</td>
</tr>
<tr>
<td>Level IV Limited Exposure</td>
<td>Out-of-Pocket expense &gt; 20% of the family income</td>
<td>60%</td>
<td>60%</td>
<td>P14</td>
</tr>
</tbody>
</table>

(continued on next page)
E. WMC will provide all-inclusive clinic services at the rates outlined in the table below for those patients who qualify for charity care.

<table>
<thead>
<tr>
<th>Charity Care Tier</th>
<th>Family Income as % Federal Poverty Level</th>
<th>All-Inclusive Clinic Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I Free</td>
<td>&lt;= 250%</td>
<td>Free</td>
</tr>
<tr>
<td>Level II Discounted</td>
<td>251% - 350%</td>
<td>$25.00</td>
</tr>
<tr>
<td>Level III Discounted</td>
<td>351% - 500%</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

F. Application Process

a. The attached application (see appendix "A") will be used by patients to apply for charity care from WMC. Patients who do not have insurance may qualify for charity care based on their monthly or annual income and their family size. Patients having insurance may also be eligible for charity care for their deductibles and coinsurance, if the services are medically necessary. Charity care policies will not apply to portions of the bill covered by insurance, except for applicable coinsurance and deductible amounts.

b. Requests for charity care may be proposed by sources other than the patient, such as the patient's physician, family members, community or religious groups, social service organizations, or hospital personnel. The patient shall be informed of such a request. This type of request shall be processed like any other and be subject to the charity care qualification guidelines.

c. The hospital shall send anyone who requests information on WMC's charity care program an application (see appendix "A") and an informational sheet about the program (see appendix "F").

d. A Medicaid application may be completed in conjunction with the charity care application for the non-insured population and the under-insured population, when appropriate. WMC will document a reasonable, good faith basis for believing the patient may be eligible for Medicaid coverage and will document the reason in the patient's records. A Medicaid application will not be completed if it is clear that the individual will not qualify for coverage under then-current Medicaid regulations.
e. WMC's charity care representatives will provide application assistance to all patients. Reading, writing and/or translation services, when needed, will be offered to all patients.

f. WMC will make all attempts to have the patient complete a charity care application at or before the time services are rendered. The patient will be allotted ninety (90) days from the date of discharge or from date of service to submit the completed application and an additional twenty (20) days to submit all required documentation.

g. If verification of financial information is needed, the hospital shall request such information from the patient. Patients may use a variety of information to substantiate financial circumstances, such as paycheck stubs, W-2 forms, income tax returns, and unemployment or disability statements. If those items are unavailable, a letter of support from individuals providing for the patient's basic living needs will be accepted. WMC may utilize third-party financial reporting services (i.e. Search America) to verify the information provided.

h. If a deposit is requested of the patient prior to non-emergency but medically necessary care, such deposit will be included as part of any financial assistance consideration.

G. Approval Process

a. The patient shall be notified in writing within ten (10) business days after receipt of the charity care application and any supporting materials as to whether the patient qualifies for the charity care program. The patient shall receive a letter and card stating that charity care eligibility will be effective for a period of one year, barring any change in the financial condition of the patient and family (see appendix "C").

b. If the patient has applied for and has been approved for charity care within the last twelve (12) months and the patient's financial circumstances have not changed, the patient shall be deemed eligible for charity care without having to submit a new charity care application.
H. Presumptive Charity Care

a. Westchester Medical Center realizes that certain individuals may not overtly request charity care assistance, even if he or she would clearly qualify under the charity policy. While the accounts for these patients will follow the normal collection process, the Medical Center may take the following action:

i. Accounts that have been returned from a collection agency as uncollectible bad debt may be reviewed further by the Medical Center using external financial and demographic data validation services provided through a nationally-recognized third party service (i.e. Search America). Such service will provide the Medical Center with, at a minimum, the individual's estimated percentage of the federal poverty level and family size (obtained through public financial records and demographic data sources).

ii. The Medical Center will use this presumptive charity care data to determine which accounts may be reclassified from bad debt to charity care, in accordance with the terms of this policy and the FPL limits outlined in paragraph seven (7) above.

iii. The documentation sent to the third party service to initiate the background and financial inquiry, as well as all results returned from the third party service, will be maintained in the Patient Accounting charity care files.

I. Denial and Appeal Process

a. If it is determined that the patient does not qualify for the charity care program, the patient shall be informed in writing within ten (10) working days of the denial. All reasons for denial shall be provided in the correspondence.

b. Included in the denial correspondence will be information about how to appeal the decision not to grant charity care (see appendix "D").

c. Each patient denied charity care may petition the hospital, in writing, within thirty (30) days for reconsideration based on extenuating circumstances.
d. Charity Care appeals will be presented to an ad-hoc Patient Relations Committee which will consist of, but not be limited to, the following individuals:

- Vice President with administrative responsibility for Patient Accounts
- Director, Patient Accounts
- Program Administrator, Patient Accounts
- Patient Relations Specialist

e. All appeals will be evaluated on a case-by-case basis taking into consideration the many unique factors impacting a patient’s ability to pay. WMC may, at its discretion, extend financial assistance beyond that required in this policy.

f. Patients will be notified of the determination or status of the appeal within thirty (30) days from receipt of the appeal from the patient.

J. Communication

a. In an effort to notify patients of the charity care program, summary information sheets outlining the Charity Care Program, the application process and contact telephone numbers for additional information shall be available at all patient registration desks and in all waiting areas (see appendix “F”). Additionally, signage indicating the availability of the charity care program will be placed at all patient registration areas.
b. WMC shall provide notice of the hospital's charity care program in English and/or Spanish during any pre-admission, admission, and discharge process (see appendix "G").

c. All hospital employees in patient accounting, billing, registration, and emergency areas will be fully trained in the hospital's Charity Care policy, have access to the application forms, and be able to direct questions to the appropriate hospital representatives.

d. All staff with public and patient contact will be trained regarding the availability of a charity care program at WMC and on how to direct patients to the appropriate representatives for assistance and further information.

e. WMC will designate individuals in the Financial Aid Office as specialists in the charity care process. These individuals will provide and / or coordinate the assistance measures outlined in this policy and will oversee all aspects of the charity care application process.

f. A statement regarding the availability of financial assistance programs, including charity care, will be included on all bills and data mailers sent to patients by WMC. Included will be information on how to contact WMC for more information or to apply for the program.

K. Collection Activities

a. Any firm contracted with the hospital for collection purposes shall also provide information to WMC patients on how to apply for financial assistance, in accordance with all provisions of this policy.

b. Accounts will not be sent to an external collection agency without the patient or his / her designee having an opportunity and adequate time to develop an alternative payment arrangement with WMC (see above). Accounts will also not be referred for collection while an application for financial assistance is pending.

c. All patients will receive a minimum of thirty (30) days written notice on data mailers / billing statements that their account is subject to referral to a collection agency.
d. WMC will not commence collection activity on any account for which financial assistance has been approved. The application for charity care (see appendix "A") will include a statement that the patient will not be responsible for any bills until such time that a decision on the application has been made.

e. All legal firms and collection agencies with whom WMC may contract for collection services will conduct all collection activities in accordance with this policy and procedure. Further, such firms shall not commence any legal proceedings on an account without the prior written consent of WMC.

f. WMC will make best efforts to work with the patient to determine an equitable payment schedule / installment plan for any out-of-pocket expenses, considering the patient’s financial and medical circumstances. The monthly payments on any installment plan will not exceed 10% of the patient’s gross monthly income and there will be no interest charges on an approved installment plan.

g. WMC, nor any law firm or collection agency with which it contracts, will not force the sale or foreclose of a patient’s primary residence to collect an outstanding bill.

h. WMC will not pursue collections against any patient who was eligible for Medicaid at the time services were rendered.

L. Record keeping

a. All charity care applications will be kept on file for five (5) years. A copy of the patient’s charity care application and all correspondence with the patient regarding the approval, denial and appeal will be maintained in the patient’s file.

b. Charity care shall be recorded using the direct write-off method and shall comply with all accounting regulations by the American Institute for Certified Public Accounting. Transaction codes and plan codes will be established in WMC’s computerized patient billing system to adequately track and report charity care activity.
M. Reporting

a. WMC shall provide a copy of the hospital's charity care program and report the amount of charity care provided in cost and charges in its annual financial statements. The hospital shall file a copy of the hospital's charity care program with all appropriate local and state agencies.

b. The Director of Patient Access/Patient Accounts will audit the charity care process by sampling a minimum of ten financial assistance/charity care applications biannually. A complete review of the documentation, correspondence with the patient and subsequent financial activity on the accounts will be reviewed. An appropriate investigation and follow-up education will be conducted in the event any deviation from this policy is uncovered.

Maria Caprio
Director, Patient Financial Services

[Signature]
Vice President, Revenue Cycle

Mark J. [Signature]
Senior Vice President, Financial Planning
ATTACHMENT A
APPLICATION FOR CHARITY CARE

WESTCHESTER MEDICAL CENTER

CHARITY CARE APPLICATION
PATIENT FINANCIAL WORKSHEET

Patient Name: ___________________________ Date: ___________________________
Medical Record Number: ___________________________ Account #: ___________________________

RESPONSIBLE PARTY:

Name: ___________________________ Spouse Name: ___________________________
Address: ___________________________ Address: ___________________________
City/State: ___________________________ City/State: ___________________________
Zip Code: ___________________________ Zip Code: ___________________________
Phone: ___________________________ Phone: ___________________________

Mailmg address (if different from above):

HOUSEHOLD INFORMATION:

Total number of dependents in household including yourself: ___________________________

Do any other person(s) contribute financially to the family? Yes: ______ No: ______

MONTHLY INCOME: (Please indicate all sources of income)

Parent / Partner: $ ___________________________

Spouse: $ ___________________________

Other income from legal dependents: $ ___________________________

Total income: $ ___________________________

ASSETS WILL NOT BE CONSIDERED FOR CHARITY CARE BUT WILL BE USED IF YOU ALSO
CHOOSE TO APPLY FOR MEDICAID:

Bank Accounts:

Savings Accounts: $ ___________________________

Checking Accounts: $ ___________________________

Other bank accounts: $ ___________________________

Other assets (list): $ ___________________________

Total assets: $ ___________________________

QUALIFYING MONTHLY INCOME

QUALIFYING HOUSEHOLD SIZE

I certify that to the best of my knowledge, all answers on this form are true and complete.

Signature: ___________________________ Date: ___________________________

Once you have submitted a complete application and the required documentation, there
is a chance that you may receive a bill in the mail while your application is being
processed. You are not responsible for that bill while your application is being
processed but please call us at 914-693-2000.
ATTACHMENT B

FEDERAL POVERTY GUIDELINES

The Department of Health and Human Services publishes updates to the Federal Poverty Level on its web site at http://aspe.os.dhhs.gov/poverty/xxpoverty.shtml (where XX indicates the specific year i.e. 09 for 2009).

For example purposes only, the table below reflects 2009 Federal Poverty Guidelines. However, the determination of eligibility for charity care will be based on the current year guidelines at the time of the patient’s application for assistance.

Table B1 – Calculation of Income Levels For Determining Eligibility for Charity Care

<table>
<thead>
<tr>
<th>Persons in Family Unit</th>
<th>45 Contiguous US States and D.C.</th>
<th>Level I ≤ 250% FPL 100% Discount</th>
<th>Level II 251% - 350% FPL 60% Discount Between...</th>
<th>Level III 351% - 500% FPL 30% Discount Between...</th>
<th>Level IV OOP &gt; 20% of income 60% Discount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10,830</td>
<td>$27,075</td>
<td>$27,183</td>
<td>$37,905</td>
<td>$38,013 $54,150</td>
</tr>
<tr>
<td>2</td>
<td>$14,570</td>
<td>$38,425</td>
<td>$36,571</td>
<td>$50,995</td>
<td>$51,141 $72,850</td>
</tr>
<tr>
<td>3</td>
<td>$18,310</td>
<td>$45,775</td>
<td>$45,958</td>
<td>$64,085</td>
<td>$64,268 $91,550</td>
</tr>
<tr>
<td>4</td>
<td>$22,050</td>
<td>$55,125</td>
<td>$55,346</td>
<td>$77,175</td>
<td>$77,396 $110,250</td>
</tr>
<tr>
<td>5</td>
<td>$25,790</td>
<td>$64,475</td>
<td>$64,733</td>
<td>$90,265</td>
<td>$90,523 $128,950</td>
</tr>
<tr>
<td>6</td>
<td>$29,530</td>
<td>$73,825</td>
<td>$74,120</td>
<td>$103,355</td>
<td>$103,650 $147,850</td>
</tr>
<tr>
<td>7</td>
<td>$33,270</td>
<td>$83,175</td>
<td>$83,508</td>
<td>$116,445</td>
<td>$116,778 $166,350</td>
</tr>
<tr>
<td>8</td>
<td>$37,010</td>
<td>$92,525</td>
<td>$92,895</td>
<td>$129,535</td>
<td>$129,905 $185,050</td>
</tr>
<tr>
<td>Ea. Add'l</td>
<td>$3,740</td>
<td>$9,350</td>
<td>$9,357</td>
<td>$13,090</td>
<td>$13,127 $18,700</td>
</tr>
</tbody>
</table>

Family income multiplied by 20% to determine maximum out-of-pocket expense to be incurred. Once reached, then 50% discount.
APPENDIX C

APPROVAL LETTER

Westchester Medical Center
WORLD-CLASS MEDICINE THAT'S NOT A WORLD AWAY.

Date:

Re: Westchester Medical Center pending account(s).

Dear [Name],

The Westchester Medical Center has reviewed your case for financial assistance, and has approved you for a ____% discount or $____ per clinic visit rate under the Charity Care Program. Below you will find the description of the account(s):

<table>
<thead>
<tr>
<th>ACCOUNT</th>
<th>ADMISSION</th>
<th>DISCHARGE</th>
<th>PREVIOUS BALANCE</th>
<th>% DISCOUNT</th>
<th>CURRENT BALANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You are responsible for $____. If responsibility is indicated, please contact our Financial Accounting Department at (914) 493-2380 to set up payment arrangements. Our facility will make every effort to continue to work with you in regard to this matter. The charity care percentage discount or reduced fee clinic rate noted above is valid for ONE YEAR from today's date, unless your financial condition changes. If so, please notify our office promptly.

Please be aware that you may receive separate bills for services provided by private physicians or specialists (i.e. x-ray interpretation, Emergency Room doctor, etc.). These bills are not covered under Westchester Medical Center’s Charity Care policy. Please contact the office of the billing physician or service to discuss specific payment arrangements.

Thank you.

Westchester Medical Center
Financial Assistance Program
(914) 493-7830
ATTACHMENT D
DENIAL LETTER

Westchester Medical Center
World-Class Medicine That's Not a World Away.

Date:
Pt:
Re: Westchester Medical Center pending account(s).

Dear

The Westchester Medical Center has reviewed the documentation you have provided for our
Financial Assistance Program. According to the documents provided, it was determined that
you do not meet the qualifications for our financial assistance / charity care program due to
excess income/excess resources.

You are responsible for $_________. Please contact our Financial Assistance Department at
(914) 493-2089 to set up payment arrangements. Our facility will make every effort to
continue to work with you in regards to this matter.

If you believe this decision is incorrect, you have a right to appeal. Please notify us, in
writing, within thirty (30) days of receipt of this letter and include any additional information
or documents that you believe should be considered. We will carefully evaluate the
additional information and respond to you in writing.

Thank you.

Westchester Medical Center
Financial Assistance Program
914-493-7830
APPENDIX E

SIGNAGE

Westchester Medical Center
Financial Assistance Program

Signs with the following language will be posted at all patient registration areas in both English and Spanish:

"WMC has a Charity Care program for patients who financially qualify. Please ask the registrar for details"

Sample:

WMC tiene un programa de Caridad para los pacientes que califican financieramente. Por favor de preguntar en la area de recepcion sobre detalles.
ATTACHMENT F

INFORMATIONAL SHEET (SUMMER HANDOUT)

Appendix F

WESTCHESTER MEDICAL CENTER

CHARITY CARE PROGRAM INFORMATION SUMMARY

Does Westchester Medical Center offer a Financial Assistance / Charity Care Program?

Yes. Westchester Medical Center remains devoted to continued excellence in patient care and serving the community. As a partner in the community, we offer a Financial Assistance / Charity Care program which allows us to provide care to patients without charge or at amounts less than our established rates.

Who qualifies for a discount and what are the income limits?

Financial assistance is available for patients with limited income and no health insurance. Although WMC's primary service area is defined as the five counties of Westchester, Putnam, Orange, Rockland, and Bronx, everyone in New York State who needs emergency services can receive care and get a discount if they meet certain income limits. The amount of the discount varies based on your income and the size of your family. Do not be afraid to apply—you may qualify even if you work or own a home or car. You may also apply for a discount regardless of immigration status. Discounted or free care starts with the income limits below:

<table>
<thead>
<tr>
<th>Number of Persons in the Family Unit</th>
<th>Annual Family Income</th>
<th>Monthly Family Income</th>
<th>Weekly Family Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$28,000</td>
<td>$2,677</td>
<td>$1,019</td>
</tr>
<tr>
<td>2</td>
<td>$30,000</td>
<td>$2,817</td>
<td>$1,132</td>
</tr>
<tr>
<td>3</td>
<td>$44,000</td>
<td>$3,867</td>
<td>$1,401</td>
</tr>
<tr>
<td>4</td>
<td>$55,000</td>
<td>$4,517</td>
<td>$1,599</td>
</tr>
<tr>
<td>5</td>
<td>$62,000</td>
<td>$5,167</td>
<td>$1,865</td>
</tr>
<tr>
<td>6</td>
<td>$71,000</td>
<td>$5,917</td>
<td>$1,972</td>
</tr>
<tr>
<td>7</td>
<td>$80,000</td>
<td>$6,567</td>
<td>$2,114</td>
</tr>
<tr>
<td>8</td>
<td>$89,000</td>
<td>$7,417</td>
<td>$2,199</td>
</tr>
<tr>
<td>Each additional person</td>
<td>$5,000</td>
<td>$750</td>
<td>$159</td>
</tr>
</tbody>
</table>

Figures based on 2009 Federal Poverty Guidelines as published by the US Department of Health and Human Services.

What services are covered?

All medically necessary services, including preventative care, are covered under the financial assistance program. This includes outpatient services, inpatient care, and emergency services. Please note that services from private doctors who provide certain services in the hospital are billed by the respective physician and may not be covered under this program.

How do I get information about the Financial Assistance / Charity Care Program?

To inquire about our Financial Assistance / Charity Care program, contact us at (914) 493-7830 or ask any of our registration staff members for an informational packet.

What do I need to do to apply for the program?

Free, confidential help is available for the program. We will help you complete an easy application and let you know of a few documents that may be needed (photo identification, pay stubs, etc.). If you, your family members, or friends do not speak English, someone will assist you in your own language.

The Financial Counselor can also tell you if you qualify for free or low-cost health insurance such as Medicaid, Child Health Plus, and Family Health Plus. If the Financial Counselor finds that you do not qualify for free or low-cost insurance, he or she will help you apply for a charity discount.

What if I have a problem that I cannot resolve with the hospital?

You can call the New York State Department of Health at 1-800-845-6447.

For more information, please see any registration specialist or call 914-493-7830. We are here to help.
APPENDIX G
PATIENT NOTIFICATION OF PROGRAM (PACKET)

Date:

Account(s):

Dear

Attached please find an application for a program the Medical Center is offering on financial assistance in order to help you pay your hospital bills. Please return the application form along with proof of income (3 months of pay stubs, prior year W-2 form, social security or disability statement, etc.). If those items are unavailable, a letter of support from the individual providing your basic living needs will be accepted. We will also require a copy of a valid photo ID (driver's license, non-driver identification card, or passport).

All of your information, including the proof of income, must be received in order to process your application. Your reply must also be received within 30 days from the date you receive this letter.

If you have any questions, please call (914) 493-7890.

You may mail this information to:

WMC Patient Accounts Department
ATTN: Financial Assistance Program
P.O. Box 277
Hawthorne, New York 10532

Or you may fax the information to (914) 493-8798.

Sincerely,

Westchester Medical Center
Financial Assistance Program
APPENDIX H

PATIENT BILLS / STATEMENTS MESSAGE

The following language shall be printed on all patient statements / bills generated by the Westchester Medical Center patient billing system:

“"To inquire about our Financial Assistance programs, including Charity Care, please contact us at (914) 493-7830""