HELEN HAYES HOSPITAL

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

Financial Assistance/Charity Care Application

This is an application for financial assistance, also known as Charity Care at Helen Hayes Hospital (HHH).

New York State requires all hospitals provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced price care based on your family size and income, even if you have health insurance. The hospital financial assistance program covers appropriate hospital-based services provided by Helen Hayes Hospital depending upon eligibility. Financial assistance may not cover all healthcare costs. To determine if you are eligible for financial assistance, you must complete this application and provide all supporting documentation. If you need assistance completing the application or have questions, please contact us at 845-786-4786.

Once you have completed the application and gathered all documentation, please submit to:

Helen Hayes Hospital
Patient Financial Services Department
51-55 Route 9W
West Haverstraw, NY 10993

Applications must be submitted within 120 days of last treatment at HHH. Once received, your application will be reviewed. If we require further documentation, we will contact you. You must complete the application within 30 days. After the application is complete, HHH will provide a response in writing to you within 30 days. If you are in disagreement, you may file an appeal with supporting documentation for reconsideration. Further details on the policies and process for this program can be found on the HHH website or by contacting us directly. Assistance is available to you at all steps of the application and appeal process.

In order for your application to be processed you must submit the following:

Household composition, including yourself (one for each family member)
- *Birth Certificates
- *Passport, Visa, Alien Registration Card, and/or Driver's License
- *Social Security Number (if applicable)

Address Verification (one of either)
- *Current Lease
- *Current Rent Receipts (2)
- *Current postmarked mail received with given address

Income Verification
- *Last 12 week pay stubs
- *Award letter from whatever source of income, including but not limited to, and all that apply:
  - *Social Security
  - *Unemployment

*Disability
*Pension/Annuity
*Child Support
*Approval/Denial of eligibility for Medicaid and/or state funded medical assistance
*List liquid assets (cash or assets that can be converted into cash without penalty)
*Other: If you do not have an income, a letter stating how you support yourself/household. If someone gives you money, free room and board, etc., a letter from that person is required.

Please complete the full application and include the documents required as stated above. If you have any questions please contact us. Upon submission of the completed application, the patient may disregard any bills until the hospital has rendered a decision on the application.

If your request for Charity Care/Financial Assistance/Fee Scaling is denied and you disagree with our determination, please submit your reason within 30 days, in writing, to:

Attention: Patient Financial Services Department
Helen Hayes Hospital
51-55 Route 9W
West Haverstraw, NY 10993

or you can contact the DOH at 1-800-804-5447 or (518) 402-6993 for additional assistance or to report complaints.

Thank You

Helen Hayes Hospital
Patient Financial Services Department

Application For Charity Care/Financial Assistance

Patient Name: _____
Dates of Service: _____
Account Number(s): _____
Balance to Date: _____

Guarantor (Person Responsible for the Bill)

Guarantor Name: _____
Guarantor Address: _____
_____
Telephone Number: Home: _____ Cell: _____
Occupation: _____
Employer(s) Name: _____
Employer(s) Address: _____
_____
Employer(s) Telephone Number: _____
Additional Employment Information: _____
_____
_____

If you have any further employment information, please attach to application on separate paper.

Household Composition (include residing in household)

Name	Date of Birth	Relation to Head of Household
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Income

Guarantor: weekly: $_____ annual: $_____

Guarantor Spouse: weekly: $_____ annual: $_____

Other Income

Unemployment:	weekly: $_____	annual: $_____
Workers Compensation:	weekly: $_____	annual: $_____
Social Security:	weekly: $_____	annual: $_____
Disability:	weekly: $_____	annual: $_____
Alimony:	weekly: $_____	annual: $_____
Child Support:	weekly: $_____	annual: $_____
Other:	weekly: $_____	annual: $_____

Please attach documentation for any relevant additional information.

Please sign Declaration on next Page.

Declaration:

I (Patient/Guarantor)_____, certify that the information contained in this application is true and correct to the best of my knowledge, If any information provided on this application proves to be false, I understand that the hospital may reevaluate my financial status and take appropriate action to rectify determination status.

I will apply for any available assistance (Medicaid, Medicare, Child health Plus, Family Health plus, etc.) which may be available for payment of my hospital charge(s), and will take any reasonable action necessary to obtain such assistance.

I further understand that this application is valid for 1 year, from_____to_____:
However, if any changes occur in my household composition or financial information within that time period, I will report it to the Patient Financial Service Department.

I give my permission to HHH to disclose this information to any Federal or State agency responsible for determining program compliance.

Patient/Guarantor Signature: _____ Date: _____