Catholic Health Services of Long Island

As a ministry of the Catholic Church, CHS continues Christ's healing mission, promotes excellence in care and commits itself to those in need. CHS affirms the sanctity of life, advocates for the poor and underserved, and serves the common good. It conducts its health care practice, business, education and innovation with justice, integrity and respect for the dignity of each person.

☐ GOOD SAMARITAN HOSPITAL ☐ MERCY MEDICAL CENTER ☐ ST. CATHERINE OF SIENA

☐ ST. CHARLES HOSPITAL ☐ ST. FRANCIS HOSPITAL ☐ ST. JOSEPH HOSPITAL

DATE: _____

Dear _____:

RE: Account Number(s): _____

Catholic Health Services of Long Island System Financial Assistance Program is designed to help patients who have received medically necessary services but are uninsured or have exhausted their medical benefits for a particular service. Eligibility for the program is based on current income and is available to individuals with family incomes less than or equal to 400% of the Federal Poverty Level (FPL). For those individuals where income is greater than 150% of the FPL, liquid assets will be considered when determining eligibility for financial assistance.

When completing the attached application for Financial Assistance please review the following:

- You have thirty (30) days from the date of this letter to complete this application
- An application is not complete until all required documentation is received. Required documentation to support family income (Patient/Guarantor and spouse) include the following:
    - The four (4) most recent pay stubs
    - Copy of Social Security payments that you and/or your spouse receive (benefit award letter or bank statement)
    - Copy of Workers Compensation benefits
    - Copy of unemployment benefits
    - The three (3) most recent bank statements (checking and savings)
    - Other income (Veterans Benefits, Rental Income, Alimony/Maintenance)
    - Proof of Student Status (Unofficial Transcript or Current Class Schedule)
    - Proof of support assistance from another person (letter from person supporting you if you are not paying rent)
    - Sign and date application
- Once we receive your completed application, you may disregard any bills/statements until you receive a written notification regarding your financial assistance application.
- Applicants for financial assistance will be expected to fully cooperate in applying for any public insurance programs that we believe you may be eligible for (e.g., Medicaid, Child Health Plus, etc.)

Complete and return application, along with supporting documentation to:

CHSLI
245 Old Country Road
Melville, NY 11747
Attn: Patient Advocacy Division or Financial Assistance Representative

Upon receipt of your completed application and all required documents, your application will be reviewed and our determination will be sent to you in writing within 30 days. If you have any questions feel free to contact us.

Sincerely,

TEL.: (631) 465 – 6321 or (631) 465 - 6244

Financial Assistance Representative
Catholic Health Services of Long Island
245 Old Country Road
Melville, NY 11747

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Applicant/Guarantor Information:

Applicant/Guarantor Name: _____ Guarantor Social Security # _____-_____-_____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: (_____)_____-_____ Cell Phone #: (_____)_____-_____ Work Phone #:(_____)_____-_____

Patient Information:

Patient Name: _____ Patient Social Security # _____-_____-_____

Date of Birth: _____/_____/_____ Account #'s: _____

Patient's Relationship to Applicant/Guarantor:

☐ Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Child ☐ Other: _____

Do you have health insurance? ☐ Yes ☐ No **If yes, please specify:** _____

Total Family Size: **List the dependents who reside in the applicant's house for whom the applicant takes financial responsibility.**

Family Size - Number in Household: _____

Check the appropriate box for each dependent

	NAME	AGE	RELATIONSHIP			
			Spouse/Partner	Parent	Child	Other
1.			☐	☐	☐	☐
2.			☐	☐	☐	☐
3.			☐	☐	☐	☐
4.			☐	☐	☐	☐
5.			☐	☐	☐	☐
6.			☐	☐	☐	☐

Total Gross Monthly Income for the last 30 days:

Source of Income	Applicant/Patient	Spouse/ Live In Partner
Wages	$	$
Social Security Payment	$	$
Unemployment Compensation	$	$
Disability Payment	$	$
Workers Compensation	$	$
Alimony / Maintenance	$	$
Dividends, Interests, Rental Income	$	$
Other Income	$	$
Total Income	$	$

Assets

- Do you rent or own home (primary residence) ☐ Rent ☐ Own
- Do you own a secondary home ☐ Yes ☐ No

Bank Accounts

- Checking Account Balance(s) $ _____
- Savings Account Balances(s) $ _____

Monthly Household Expenses $_____

Outstanding Medical Expenses (please list) $_____

Certification by Applicant

I certify to the best of my knowledge that the information and documentation provided is truthful, complete and accurate. I understand that the information which I submit is subject to verification by the appropriate facility and any willful misrepresentation of these facts will make me liable for all Hospital charges. I will apply for governmental or private medical assistance for payment of my medical expenses. I understand that it is my responsibility to promptly advise the Hospital of any changes to my income or assets.

X _____ _____ / _____ / _____

Applicant Signature/Patient Signature (Parent/Legal Guardian-Minor Child) Date

Please return completed applications with supporting documentation to the providing facility or mail completed applications to:

CHS HOSPITAL - Financial Assistance Department
Address Line 1
City, State xxxxx