BON SECOURS CHARITY HEALTH SYSTEM
APPLICATION FOR CHARITY CARE/FINANCIAL ASSISTANCE CARE CARD

PART A: INFORMATION FOR CHARITY CARE/ FINANCIAL ASSISTANCE APPLICATION ONLY

Name: _____

Address: _____

_____

Date of Birth: _____ Telephone: _____

Family Size/Number in Household: _____. Identify each member of your household:

Name	Age	Relationship

Employment of Each Member of Your Household:

Name of Person Employed	Employer	Gross Pay
		$ wk mo
		$ wk mo
		$ wk mo
		$ wk mo

Household Income (Attach Proof of Income):

	Patient Income	Spouse or Other Income
Wages, salary, tips from employment		
Social Security payment		
Unemployment compensation		
Disability		
Worker's compensation		
Alimony/child support		
Dividends/interest/rentals		
All other income		
TOTAL		

Insurance:

Blue Cross ID# _____ Group _____ Policy Holder _____

Medicare # _____ Suffix _____

Other Ins. Name _____ Policy Number _____ Policy Holder _____

Insurance Deductible/Co-Pays $_____

PART B: FOR MEDICAID APPLICANTS ONLY

Personal Assets

Cash on Hand/Money in Bank/Savings Acct(s) $_____ Bank _____

Checks/bonds/Securities (Cash Value) $_____

Primary residence (Cash Value) $_____

Other Real Estate (Cash Value) $_____

* * * * * * * * * * *

I hereby request that Bon Secours Charity Health System make a written determination of my eligibility for charity care/financial assistance. I understand that, if the information which I submit is determined to be false, such determination may result in a denial of my application and that I may be liable for charges for services provided. I certify that the above information is true, complete, and correct to the best of my knowledge.

If hospital has a reasonable basis for believing that a patient may be eligible for Medicaid or other publicly sponsored insurance program, the hospital will have the right to require patient(s) to cooperate in applying with the hospital or their agent, MedData, for such coverage as a condition for receipt of Financial Assistance.

Signed: _____ Date: _____

Bon Secours Health System reserves the right to validate information reported in this application. Efforts to validate personal income, or lack thereof, will be conducted in such a manner as to maintain the utmost confidentiality and will in no way generate any report by any credit bureau agency that could adversely impact the applicant.

If you have received a bill or bills from the Hospital, check here: _____

Once you have submitted a completed application and supporting documentation to the Hospital at the address below, you may disregard any bills until the Hospital has rendered a written decision on your application.

If you have any questions or need help completing this application, please call the Hospital's Charity Care/Financial Assistance Office at (866) 534-6702 or go to the Admitting/Registration Department at the one of the hospitals below:

Bon Secours Community Hospital, **160 East Main St., Port Jervis, NY 12771**
Good Samaritan Hospital, **255 Lafayette Ave. (Route 59) Suffern, NY 10901**
St. Anthony Community Hospital, **15 Maple Avenue, Warwick, NY 10990**

PLEASE FILL OUT AND RETURN TO:

Bon Secours Charity Health System
Charity Care/Financial Assistance Office
400 Rella Blvd. Suite 308
Montebello, NY 10901
Charity Care/Financial Assistant: Toll free (866) 534-6702
Customer Service Center: (844) 419-2701

**********DO NOT WRITE BELOW THIS LINE**********

Approved _____ Amount $_____ Date _____

Eligible Period _____ to _____

Applicant's Share $_____Approved By _____

Denied _____ Date _____

Reason _____

Denied by _____