BON SECOURS CHARITY HEALTH SYSTEM
APPLICATION FOR CHARITY CARE/FINANCIAL ASSISTANCE
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) $_____

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.

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.

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 _____