White Plains Hospital

FINANCIAL ASSISTANCE PROGRAM (CHARITY CARE)

White Plains Hospital recognizes that there are times when patients in need of care will have difficulty paying for the services provided. White Plains Hospital's Financial Assistance Program provides discounts to qualifying individuals based on your income. In addition, we can help you apply for free or low-cost insurance if you qualify. Contact our Financial Counselor at (914) 681-1030 for confidential assistance.

Financial Assistance is available for patients with limited income and no health insurance. **Everyone in New York State who needs emergency services can receive care and get a discount if they meet the income limits.**

Everyone who lives in **Westchester, Bronx, Putnam, Orange, or Rockland**, can get a discount on non-emergency, medically necessary services at White Plains Hospital if they meet the income limits. **You cannot be denied medically necessary care because you need financial assistance**. Applications are accepted at any time on an account with an open balance.

When applying, you must provide **COPIES** of the following:

1)	Valid photo identification
2)	Proof of income: Current pay stubs (last 6), employer statement indicating how much is made weekly or biweekly, Social Security Income Letter (if applicable) OR self-declaration of income (if paid in cash). **If you do not have any income, please attach written statement, and explain how you meet your living expenses. No notary stamp needed**
3)	One proof of address (Utility bill; Con Ed, phone bill, cable, etc.– it does not have to be under applicant's name)
4)	Last 3 months of bank statements of all accounts, if applicable (**Please submit ALL pages**)

- **If married, please provide spouse's ID and proof of income.**

If you think you may be eligible for Financial Assistance and wish to request it, please contact the patient account department at **(914) 681-1004**. White Plains Hospital will send you a letter within **30 days** after completion and submission of documentation, telling you if you have been approved and the level of discount received.

Please mail completed application and copy of requested documents to:

White Plains Hospital Center
41 East Post Road
White Plains, NY 10601
Attention: Patient Accounts

You can also email application to: **FinancialAssistance@wphospital.org**

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Document Checklist for Patients

Applications submitted without the appropriate supporting documents will be considered incomplete and will not be approved until all information is received. The purpose of this checklist is to help applicants make sure they're submitting all the required documents to avoid approval delays.

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1. **Valid proof of identification** (Please submit a copy of **ONE** the following per adult)

   - ☐ Driver's license
   - ☐ Passport book or card
   - ☐ Official government identification card
   - ☐ School identification card
   - ☐ ID from your country of origin
   - ☐ If applying for a minor, please submit parents or authorized representative's ID

2. **Proof of income** (Each income-earning adult must provide at least **ONE** of the following)

   - ☐ 6 most recent paystubs or unemployment award letter
   - ☐ Employer statement indicating how much is made weekly or biweekly
   - ☐ Social Security Income Letter (if applicable)
   - ☐ Self-declaration of income (if paid in cash) No notary stamp needed
   - ☐ If you do not have any income, please attach written statement, and explain how you meet your living expenses. No notary stamp needed
   - ☐ If applying for a minor, please submit parents or authorized representative's income

3. **Proof of address** (Please submit copy of **ONE** of the following per application)

   - ☐ Public service bill (Electric, gas, cable, phone bill, water, etc. – it does not have to be under applicant's name)
   - ☐ Rental lease agreement
   - ☐ School schedule with visible school address (Only for college students applying for financial assistance who dorm at their school)

PLEASE DO <u>NOT</u> SUBMIT ANY OF THE FOLLOWING:

- Birth certificates or employer badge as proof of ID. Credit card statements, mortgage statements, rent receipts or hospital bills as proof of address. W2, taxes or 1099 forms as proof of income. Bank statements are <u>not</u> considered proof of income or address.

White Plains Hospital

RECEIVED

FINANCIAL ASSISTANCE PROGRAM (CHARITY CARE)

PATIENT DEMOGRAPHICS					
Patient name:	**DOB:**	**Phone number:**			**County:**
Address: _____ APT # CITY STATE ZIP CODE					**Social security #** ☐ **No social security**
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Widowed			**Insured:** ☐ Yes ☐ No	**If yes, Ins name** _____ **Policy #** _____	**Family size:**
Spouse's name (If applicable):	**DOB:**		**Insured:** ☐ Yes ☐ No	**If yes, Ins name** _____ **Policy #** _____	**Social security #** ☐ **No social security**
Patient's Employer:	☐ **Unemployed**	**Spouse's Employer:**			☐ **Unemployed**

*** IF PATIENT IS A MINOR, PLEASE INCLUDE EMPLOYMENT INFORMATION OF PARENT(S)**

LIST HOUSEHOLD DIRECT MEMBERS/DEPENDENTS (IF NOT LISTED ABOVE)

NAME	RELATION TO PATIENT	DOB

DATE(S) OF SERVICE: _____

ACCOUNT NUMBER(S): _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION FURNISHED TO WHITE PLAINS HOSPITAL IS TRUE AND CORRECT. I AUTHORIZE WHITE PLAINS HOSPITAL TO VERIFY ANY INFORMATION GIVEN ABOVE, IF DEEMED NECESSARY.

Signature of Applicant/Authorized representative:

_____ Date: _____

White Plains Hospital

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Individual written notice to all patients notices of availability of Financial Assistance
In recognition that all patients who seek health care from White Plains Hospital may not have the financial resources or insurance coverage to afford care, the Hospital will make available a reasonable number of uncompensated services to persons meeting the eligibility requirements. Patient eligibility for financial assistance is determined by measuring family income against the Federal Income Poverty Guidelines established by the Department of Health and Human Services.

▼ BELOW IS FOR HOSPITAL USE ONLY ▼

DETERMINATION FOR FINANCIAL ASSISTANCE

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PATIENT NOTIFICATION OF DETERMINATION OF FINANCIAL ASSISTANCE FUNDS:

DENIAL REASON:

_____
_____
_____

IF APPEAL, APPEAL NOTICE

DATE: _____ RESOLUTION: _____

HOUSEHOLD DEMOGRAPHICS: **INCOME: $ _____** **ASSETS: $ _____** **TOTAL: $ _____** **FAMILY SIZE: _____**
FINANCIAL ASSISTANCE APPROVAL **TIER _____** **APPROVAL YEAR _____**