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 Assistance Specialist(s) at (914) 681-1004 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)

- **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
101 East Post Road, Floor 3
White Plains, NY 10601
Attention: Patient Accounts

You can also email application to:
WPH-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.

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.

NYS Uniform Hospital Financial Assistance Application

You may be eligible for hospital financial assistance to pay your bills if you are uninsured, if your insurance is exhausted, or if you have health insurance but have proof of paid medical expenses totaling more than 10% of your income. Completing this form will start your request for hospital financial assistance. This form is used by all hospitals in New York State.

This application must be printed in the primary[1] languages spoken by patients served by the hospital.

Patient Name (complete information that is applicable)

Patient Name (First, Middle, Last)		
Date of Birth (mm/dd/yyyy)		
Address	Apartment/Unit #	
City	State	Zip
Contact Phone #		
Parent/Guardian or Lawful Representative Name (if patient is a minor child or an incapacitated adult)		
Email Address (if any)		

Family Information:
Please list below all family members in your household. Your household includes yourself, your spouse or domestic partner, and any children or other dependents. For example, this would include everyone listed on the same tax return.

Gross income means your income **before** taxes are deducted.

Gross income can consist of work earnings (wages, salaries, tips, earnings from self-employment), unearned income (social security, disability, and unemployment benefits), contributions (funds from family or friends), and other sources of income (temporary assistance and supplemental security income).

Full Name	Relationship	Total Gross Income (Current)
	Self	

[1] "Primary languages" includes any language that is used to communicate in at least 5% of patient visits per year, or any language spoken by more than 1% of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems.

The hospital may request you submit documentation as proof of income; examples of documentation might include a pay stub, a letter from your employer if applicable, or Form 1040.

Health Insurance Status

Do you have any form of health insurance, including Medicaid, Medicare, or private insurance through your employer or purchased on your own? ☐ Yes ☐ No

If you answered "No," would you like assistance in applying for any of these programs?

☐ Yes ☐ No

Underinsured patients: people with insurance and high medical expenses. If you have insurance, please provide an estimate of the medical bills you paid in the past 12 months.

$

The hospital may request you submit documentation as proof of paid medical expenses.

Patient/Responsible Party: If not the patient, list the name of the person signing the form and their authority to sign on behalf of the patient (e.g., spouse, parent, legal representative).

I understand that the information I submit may be subject to verification from external sources. I certify that the information is true and complete to the best of my knowledge.

Print Name Relationship to Patient	Date
Signature	

Request for Proof of Household Income

Please include the income information for the patient, their spouse, and any dependents (such as children). For example, this would include everyone on the same tax return (tax filer, spouse, and tax dependents) in the calculation of household income.

The following is a list of documents you can use to prove your income. You do not have to provide all these documents. You can also provide a statement of no household income if you have no income.

You may also provide the Eligibility determination page from the NY State of Health Marketplace. If you have this document, you do not have to provide any other income information listed below to the hospital.

If Household Receives:	Amount per Month:	Applicant May Provide:
Wages	$	Please provide one Paycheck Stub, or Letter from Employer on company letterhead, signed and dated, or most recently filed income tax return.
Social Security Payment	$	Copy of award letter/certificate, or correspondence from the U.S. Social Security Administration, or annual benefit letter. To request a copy of your Social Security benefit letter, call 1-800-772-1213 or visit www.ssa.gov.
Unemployment Compensation	$	Copy of award letter/certificate, or monthly benefit statement from NYS Department of Labor, or Copy of Direct Payment Card with printout, or Correspondence from the NYS Department of Labor, or Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us).
Disability Payment	$	Copy of award letter/certificate, or correspondence from Social Security Administration, or copy of annual benefit letter. To request a copy of your benefit letter, call 1-800-772-1213 or visit www.ssa.gov.
Workers Compensation	$	Copy of Award Letter or Check stub.
Alimony/Child Support	$	Copy of court order, or 3 months of cashed checks/receipts.
Dividends/Interest	$	Quarterly dividend statements or 1 month statements.
Other	$	Letter stating the amount of non-wage earnings (if any), such as rental income, cash for odd jobs, etc.
No Income	$0	Signed statement of no income.

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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 _____

Date revised: 11/21/2024