St. Vincent's Hospital Westchester

A Division of Saint Joseph's Medical Center

Patient Name:_____
Account Number(s): _____
Date(s) of Service: _____
Date:

St. Vincent's Hospital Westchester recognizes that there are times when patients in need of care will have difficulty paying for the services provided. SVW 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. Just contact our Financial Counselor or go to the Benefits Office located on the ground floor of the Doty Building for free, confidential assistance.

1. **Who qualifies for a discount?**

   Financial Assistance is available for patients with limited incomes/financial resources and no health insurance.

   Everyone in New York State who needs medially necessary services can receive care and get a discount if they meet the income limits.

   Patients/guarantors who provide the required information, documentation and/or self-attestation to allow us to determine financial need.

   You may apply for a discount regardless of immigration status.

2. **What are the income limits?**
   The amount of the discount varies based on your income, assets and the size of your family. If you have no health insurance, these are the income limits*:

Family Size	Annual Family Income	Monthly Family Income	Weekly Family Income
1	Up to $39,195	Up to $3,266	Up to $754
2	Up to $52,780	Up to $4,398	Up to $1,015
3	Up to $66,365	Up to $5,530	Up to $1,276
4	Up to $79,950	Up to $6,662	Up to $1,538
5	Up to $93,535	Up to $7,795	Up to $1,799
6	Up to $107,120	Up to $8,927	Up to $2,060

*Based on the 2017 Federal Poverty Guidelines

3. **What if I do not meet the income limits?**

   SVW offers Self Pay Pricing for patients who have financial needs in paying their bill.

   If you cannot pay your bill, SVW offers a payment plan to those patients that meet the income limits. The amount you pay depends on the amount of your income.

4. **Can someone explain the discount? Can someone help me apply?**
   Yes. Free, confidential help is available in the Benefits Offices.

If you do not speak English, someone will help you in your own language.

The Financial Counselor can tell you if you qualify for free or low-cost insurance, such as Medicaid, Child Health Plus and Family Health Plus.

If the Financial Counselor finds that you don't qualify for a low-cost insurance, they will help you apply for a discount. The Financial Counselor will help you fill out all the forms and tell you what documents you need to bring.

5. **What do I need to apply for a discount?**
   - Proof of Identity (Driver's License, Permanent Registration card, Marriage License, Birth, Baptismal, Passport, or Citizenship Certificate)
   - Proof of Residence (rent receipt, utility bills, etc.)
   - Proof of Income (Pay stubs, W-2, Social Security checks, Unemployment, Disability, Letter of Support, etc.)
   - Assets (Bank Accounts, Real estate, etc.)

   If you cannot provide any of these, you may still be able to apply for financial assistance.

6. **What services are covered?**
   All medically necessary services provided by SVW are covered by the discount. This includes outpatient services, emergency care and inpatient admissions.

   Charges from private doctors who provide service in the hospital may not be covered. You should talk to private doctors to see if they offer a discount or payment plan.

7. **How much do I have to pay?**
   The amount for an outpatient service starts as low as $12.00 per visit depending on your income.

   Our Financial Counselor will give you the details about your specific discount(s) once your application is processed.

   A deposit is required for any scheduled, non-emergent services.

8. **How do I get the discount?**
   You have to fill out the application form. As soon as we have proof of your income, residency and assets, we can process your application for a discount according to your income level.

   You can apply for a discount before you have an appointment, when you come to the hospital to get care or when the bill comes in the mail. You have up to ninety (90) days after receiving the services to submit the application.

   Send the completed application from to:

   St. Vincent's Hospital Westchester
   Patient Accounts Department
   275 North Street
   Harrison, New York 10528
   Attn: Financial Counselor

9. **How will I know if I was approved for the discount?**
   SVW will send you a letter within thirty (30) days after completion and submission of all required information and documentation, to tell you if you have been approved and the level of discount received.

10. **What if I receive a bill while I'm waiting to hear if I can get a discount?**
    You cannot be required to pay a hospital bill while your application for a discount is being considered. If your application is turned down, the hospital must tell you why in writing and must provide you with a way to appeal this decision to a higher level within the hospital.

11. **What if I have a problem I cannot resolve with the hospital?**
    You may call the New York State Department of Health complaint hotline at 1-800-804-5447.

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FINANCIAL ASSISTANCE APPLICATION

Please Print

Patient's Name:_____

Hospital/Clinic & Account Number(s): _____

Type of Service: ____**Clinic** __**Emergency** __**Inpatient**

Address	City/State/Zip	Telephone #	Cell Phone or Other Contract (Name & Phone #)
Date of Birth	Social Security #	Employer	Address / Phone #
If minor – Parent's Names	Social Security #	Employer	Address / Phone #
Family Members:	Dates of Birth:	Social Security #s	Name of Bank / Address & current balance:
Family's Annual Income:	Rent or Own? Monthly payments	Assets: (Current value) Home Car(s) Motorcycle	Credit Cards and Balance Due:

Situational Information / Please describe you current financial situation / hardships:

_____

_____

_____

Applicant Statement:

I certify that the above information is correct. I understand that the information, which I submit, is subject to verification by St.Vincent's Hospital Westchester and subject to review. Further, I will take all steps necessary to apply for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge. I will take any action reasonably necessary to obtain such assistance and will assign or pay the hospital the amount recovered for hospital charges. I understand that if any of the information I have given proves to be untrue, the hospital may re-evaluate my financial status and take whatever action it deems appropriate.

_____ _____

Signature (Patient or Guarantor Date

_____ _____

Print Name Relationship to Patient