SUNY Downstate Medical Center

150 YEARS OF MEDICAL EDUCATION 1860-2010

FINANCIAL ASSISTANCE PROGRAM / CHARITY CARE

As per your request, attached is the form to be completed for Charity Care and Financial Assistance. Please complete the attached application to determine your eligibility for Financial Assistance/Charity Care at SUNY Downstate Medical Center University Hospital of Brooklyn (UHB).

Charity Care is available only to those household with savings, investments and other assets less than $10,000.00. You are entitled to exclude your primary house, car and retirement. UHB requires applications to apply for Medical benefits where appropriate. If you do not qualify for Medicaid, please attach a copy of your letter o "Notice of Decision on your Medical Assistance Application" from the Medicaid Program or screening by the Patients Financial Services Department. Completed application should be submitted no later than 90 (ninety) days from the date of discharge or service.

You will be notified of our decision within ten (10) days from receipt of the required documents. You do not have to pay your bill while you are waiting for a decision regarding your application.

Please mail completed Application Forms to the Patients Financial Services Department/Billing Office of the facility where you received your care. If you have any questions or need interpreter services, you may also call the telephone numbers listed below.

University Hospital of Brooklyn @ Central Brooklyn/UHB @ Bay Ridge	
Billing Department 711 Parkside Avenue Brooklyn NY 11225 Attn: Financial Analyst	**Patient Access Financial Services** 445 Lenox Road – Box 125 Brooklyn NY 11226 Attn: Financial Analyst
Inpatient Admission (718) 826-4933 (718) 826-4990	**Patient Access** (718) 270-1031 (718) 270-1941 (Fax)
Outpatient Services (719) 826-4918 (718) 826-4990	

Thank you.

Account Representative: _____

Phone Number: _____

Date: _____

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Application for Financial Aid/Charity Care

1. **NAME:** _____

First *Middle* *Last* *Suffix (I,II, III, Jr, Snr, etc.)*

ADDRESS: _____

Number and Street *City* *State* *Zip Code*

TELEPHONE NO: _____ **CELL PHONE NO:** _____

2. **OCCUPATION:** _____ **RATE OF PAY $**_____ *(Hourly/Weekly/Monthly)*

EMPLOYER: _____

Name *Address*

3. **HOSPITAL INSURANCE:** _____ **POLICY NUMBER:** _____

(Name of Insurance Company/Group Plan)

4. **DATE OF SERVICE:** _____

_____

5. **TYPES & FREQUENCY OF SERVICES:** _____

_____

6. **INCOME LIST COMBINED INCOME FOR YOURSELF, SPOUSE AND OTHER DEPENDENTS**

✹ **(Please submit documentation)** ✹

	TOTAL BY MONTH	TOTAL FOR LAST TWELVE (12) MONTHS
Wages		
Farm or Self Employment		
Public Assistance		
Unemployment/Workers Compensation		
Strike Benefits		
Alimony/Maintenance		
Child Support		
Military Family Allotments		
Pension		
Investment Income (*Dividends, Interest, Etc.*)		
Other		

TOTAL INCOME*: Monthly $* _____ *Yearly $* _____

7. **FAMILY SIZE:** *(Please use back of this form if more space is required)*

Name: Age: Relationship:

_____

_____

_____

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OUT-PATIENT - Charity Care Fee Scale

LEVEL	ANNUAL INCOME RANGE			FAMILY SIZE	
	Low	High	% FPL	Up to 2	3+
A	$10,830.00	$20,799.00	100%	3%	1%
B	$20,800.00	$41,999.00	200%	8%	4%
C	$42,000.00	$52,800.00	300%	12%	9%
D	$52,801.00	$70,400.00	400%	19%	13%
E	$70,401.00	$88,000.00	-	24%	20%
F	$88,001.00	$105,000.00	-	27%	25%
G	$105,601.00	$125,000.00	-	32%	28%
H	$125,000.00	$150,000.00	-	39%	33%
I	$151,000.00	+>	-	40%	40%

The Out-Patient Fee Scale will be applied against the current charge rate incurred for each service.

IN-PATIENT - Charity Care Fee Scale

LEVEL	ANNUAL INCOME RANGE			FAMILY SIZE	
	Low	High	% FPL	Up to 2	3+
A	$10,830.00	$20,799.00	100%	10%	5%
B	$20,800.00	$41,999.00	200%	20%	11%
C	$42,000.00	$52,800.00	300%	30%	21%
D	$52,801.00	$70,400.00	400%	45%	31%
E	$70,401.00	$88,000.00	-	65%	46%
F	$88,001.00	$105,000.00	-	85%	66%
G	$105,601.00	$125,000.00	-	100%	86%
H	$125,000.00	$150,000.00	-	125%	101%
I	$151,000.00	+>	-	150%	126%

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Documentation Required for Proof of Income and Expenses to apply for Financial Aid/Charity Care. Failure to submit documentation may disqualify you for any possible Financial Aid/Charity Care.

- **Identification – Valid picture ID (Passport, Driver's License, Non-Driver ID, Citizenship, etc.)**
- **Income Tax Return, or if not filed, a letter from Employment Verification Income for the last four (4) pay period or Payroll Stubs from employer.**
- **Savings Account(s), CDs, and other Investments.**
- **Unemployment Insurance Stubs.**
- **Mortgage Statements**
- **Support Payments – Divorce or Separation.**
- **Other Benefits such as Retirement Benefits, Workers Compensation, Pension, Social Security etc.**
- **Letter of Support from responsible party, with Income Documentation.**
- **Receipts for rent, gas electric, telephone Expenses etc.**

All documentation shown should be enclosed to justify your income and expenses. If you have any question, please call us at the telephone listed.

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Account Representative/Financial Counselor, Manager