ENH
Committed to Caring

EASTERN NIAGARA HOSPITAL
521 East Avenue
Lockport, New York 14094
(716) 514-5700

Outpatient Sites
5875 Transit Road
Lockport, NY 14094
2600 William Street
Newfane, NY 14108

ARE YOU UNINSURED??

A CERTIFED APPLICATION COUNSELOR IS AVAILABLE BY APPOINTMENT AT EASTERN NIAGARA HOSPTIAL-LOCKPORT SITE Room 2104

APPLY FOR:
MEDICAID
ESSENTIAL PLAN
CHILD HEALTH PLUS AND
Coverage through the Marketplace Exchange

TO SCHEDULE AN APPOINTMENT at Eastern Niagara Hospital:

Fidelis:

Monday, Wednesday & Thursday 9:00am – 12:00pm
Tuesday 9:00 a.m. – 11 a.m.
Christine Hurley – 716-364-4890

YOU WILL NEED TO SUPPLY THE FOLLOWING:

1. *Last 4 weeks (most recent and consecutive) proof of income for **all** income in the household. Income includes: wages, child support, annuities, Social Security etc.*

2. *If anyone in the household is self-employed, we will need a **signed and dated** copy of the previous year's **federal** income tax return.*

3. *Social Security Numbers and date of birth for all applying household members.*

Please notify us at 716-514-5898 once you have had your interview.

WE ARE HERE TO HELP YOU, PLEASE CALL TODAY!

3-19

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EASTERN NIAGARA HOSPITAL CHARITY CARE POLICY

STATEMENT OF POLICY

Eastern Niagara Hospital's Charity Care Policy is a policy that seeks to serve the health care needs of the community by providing free or discounted care to patients who are in need of care, but may not be able to pay for the services they receive because of limited or nonexistent insurance coverage and/or financial resources.

QUALIFICATIONS

Qualifications for the program are based on the household income in relation to the total number of dependents in the household. The household income guidelines used in determining a patient's eligibility for the program are listed below. Please note: The income levels will be used as a general guideline. Failure to meet these guidelines will not automatically disqualify a recipient for Charity Care approval. Catastrophic situations or extenuating circumstances often exist. Each account determination will be made taking into consideration all available information. If you are denied Charity Care you have the right to appeal the decision.

REQUIREMENTS

To ensure all patients requesting consideration for the qualification of Charity Care are considered equally and fairly, the patient and/or legal representative are required to follow these guidelines.

1. Complete the Charity Care Application form.
2. Provide proof of income. Income may be provided by using one or more of the following: income tax return, wage statement, unemployment check, social security or pension check or any other proof of income.

	100% Discount	75% Discount	50% Discount	25% Discount	Cap Rate
Family Size	Income less than	Income Less than	Income less than	Income less than	Income less than
1	$12,490	$18,735	$24,980	$31,225	$37,470
2	$16,910	$25,365	$33,820	$42,275	$50,730
3	$21,330	$31,995	$42,660	$53,325	$63,990
4	$25,750	$38,625	$51,500	$64,375	$77,250
5	$30,170	$45,255	$60,340	$75,425	$90,510
6	$34,590	$51,885	$69,180	$86,475	$103,770
7	$39,010	$58,515	$78,020	$97,525	$117,030
8	$43,430	$65,145	$86,860	$108,575	$130,290

**For each additional person add $5,530.

***Discount is not off of charges, it is off a capped rate.

02-19

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CHARITY CARE APPLICATION

PATIENTS NAME:_____

ADDRESS:_____

GUARANTOR'S NAME:_____

TOTAL HOUSEHOLD
INCOME:_____ $_____ $_____ $_____
WEEKLY MONTHLY YEARLY

**ATTACH PROOF OF INCOME

HOUSEHOLD MEMBERS

NAME	BIRTHDATE	S.S#	RELATIONSHIP

Do you or any family members listed above have any other open accounts with Eastern Niagara Hospital? Yes____ No____
If Yes, please provide us with the account numbers and/or dates of service:

Patient's Name	Account #	Date of Service	Amount

Please return or mail this completed application along with proof of income to:

Eastern Niagara Hospital
Attn: Patient Accounting
521 East Avenue
Lockport NY 14094

If you have any questions or concerns, please call us at (716) 514-5898.

APPLICANTS SIGNATURE:_____ **DATE:**_____
CERTIFICATION: In signing this application, I swear and affirm that the information I have given or will give to Eastern Niagara Hospital as a basis for Charity Care is correct.

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POLÍTICA DE ATENCIÓN BENÉFICA DEL EASTERN NIAGARA HOSPITAL

DECLARACIÓN DE LA POLÍTICA

El objetivo de la política de atención benéfica del Eastern Niagara Hospital es el de atender las necesidades sanitarias de la comunidad, brindando atención gratuita o con descuento a aquellos pacientes que lo necesiten, pero que no puedan costear los gastos de los servicios que reciben, debido a que poseen una cobertura médica insuficiente o a que carecen de ella y/o de recursos financieros.

ADMISIBILIDAD

La admisibilidad para el programa se basa en los ingresos del grupo familiar, con relación a la cantidad total de personas a cargo en la casa. Se utilizan las pautas sobre los ingresos del grupo familiar que se mencionan a continuación, para determinar la admisibilidad del paciente para el programa. Nota importante: los niveles de ingreso se usarán como una pauta general. El hecho de no cumplir estas pautas no descalificará automáticamente a un beneficiario para que se le apruebe la atención benéfica. A menudo se presentan situaciones catastróficas o circunstancias atenuantes. La determinación sobre cada cuenta se tomará considerando toda la información disponible. Si le niegan la atención benéfica, usted tiene derecho a apelar tal decisión.

REQUISITOS

Para garantizar que todos los pacientes que solicitan la atención benéfica sean considerados con equidad y justicia, se requiere al paciente y/o al representante legal que sigan estas pautas.

1. Completar el formulario de solicitud de atención benéfica.
2. Presentar un comprobante de ingresos. Los ingresos pueden demostrarse mediante uno o más de los siguientes: declaración de impuesto a las ganancias, declaración de salario, cheque del seguro de desempleo, seguro social o cheque de pensión o cualquier otro comprobante de ingresos.

	100% de descuento	75% de descuento	50% de descuento	25% de descuento	Margen fijo
Miembros en el grupo familiar	Ingresos inferiores a	Ingresos inferiores a	Ingresos inferiores a	Ingresos inferiores a	Ingresos inferiores a
1	$12,490	$18,735	$24,980	$31,225	$37,470
2	$16,910	$25,365	$33,820	$42,275	$50,730
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6	$34,590	$51,885	$69,180	$86,475	$103,770
7	$39,010	$58,515	$78,020	$97,525	$117,030
8	$43,430	$65,145	$86,860	$108,575	$130,290

** Para cada persona adicional, agregar $5,530.

*** El descuento no se toma de los gastos, sino del margen fijo .

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SOLICITUD PARA LA ATENCIÓN GRATUITA

NOMBRE DEL PACIENTE: _____

DOMICILIO: _____

NOMBRE DEL GARANTE: _____

INGRESOS TOTALES DEL
GRUPO FAMILIAR: $_____ $_____ $_____
SEMANAL MENSUAL ANUAL

** ADJUNTAR COMPROBANTE DE INGRESOS

MIEMBROS DEL GRUPO FAMILIAR

NOMBRE	FECHA DE NACIMIENTO	N.° SEG. SOC.	RELACIÓN

¿Usted o alguno de los miembros de la familia listados más arriba tienen alguna otra cuenta abierta en el Eastern Niagara Hospital? Sí ____ No____
Si responde que sí, indíquenos los números de cuenta y/o las fechas de servicio:

Nombre del paciente	N. de cuenta	Fecha de servicio	Importe

Entregue esta solicitud completa o envíela por correo, junto con el comprobante de ingresos y el rechazo de Medicaid a:
Eastern Niagara Hospital
Patient Accounting
521 East Avenue
Lockport NY 14094

Si tiene alguna duda o inquietud, puede comunicarse con la coordinadora de Créditos y Cobranzas, al 716-514-5898.

FIRMA DEL SOLICITANTE:_____ **FECHA:**_____

CERTIFICACIÓN: al firmar esta solicitud, juro y afirmo que la información que he suministrado o que suministraré a Eastern Niagara Hospital como fundamento para recibir esta atención benéfica es correcta.

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