Financial Assistance Application Instructions

Dear Patient:

The Continuum Health Partners Financial Assistance Program is designed to assist you with your medically necessary services. If you are uninsured or have exhausted your benefits for a particular service and if your household income is less than the amount shown below, you may be eligible for this program:

<table>
<thead>
<tr>
<th>Family/Household Size</th>
<th>2012 Maximum Household Income (400% of Federal Poverty Level)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$44,680</td>
</tr>
<tr>
<td>2</td>
<td>60,520</td>
</tr>
<tr>
<td>3</td>
<td>76,360</td>
</tr>
<tr>
<td>4</td>
<td>92,200</td>
</tr>
<tr>
<td>5</td>
<td>108,040</td>
</tr>
<tr>
<td>6</td>
<td>123,880</td>
</tr>
<tr>
<td>7</td>
<td>139,720</td>
</tr>
<tr>
<td>8</td>
<td>155,560</td>
</tr>
</tbody>
</table>

For families/households with more than 8 persons, add $15,840 for each additional person.

When you complete our application for Financial Assistance please remember the following:

- Complete the application and submit it to the Department of Financial Counseling Department.
- Your application is not complete until all required documentations are received.
- Once we obtain your completed application, you can disregard any hospital bills/statements until you receive written notification regarding your financial assistance application.
- You can either return your application in person or mail it to:
  
  Beth Israel Medical Center  
  Patient Financial Counseling Department  
  307 First Avenue, New York, NY 10003-2929

For more information please call us at the Department of Financial Counseling at 1-212-844-1914
Financial Assistance Application

Patient Financial Counseling Department
307 First Ave. New York, NY 10003
Phone: 212-844-1914
Fax: 212-505-6910

Patient Financial Assistance Program Application
If you need any help with this form, please call 212-844-1914

Patient Name ___________________________ PLT # Official use only

Guarantor (Optional) __________________________________________________________

Address __________________________________________ Phone # _____________

Employer ____________________________________________________________

Spouse’s Name ___________________________________________________________________

Spouse’s Employer ____________________________________________________________

Insurance Name (If applicable) __________________________________________________

Insurance ID#_____________________________ Phone #___________________________

Documentation Requirements:
Please provide copies of these documents with your application no later than 30 days after your initial screening.

A) Please provide one of the following documents for proof of identity:
   Photo Identification or 3 signed documents attesting to your identity.

B) Please provide one of the following documents for proof of address:
   Lease, letter from landlord, utility bill or current mail.

C) Please provide one of the following documents for income verification:
   Last 4 paystubs (or last 2 paystubs if you are paid biweekly), an unemployment benefit award letter or letter of support. If you are self-attesting to your income, please complete and sign the self-attestation form.

Income Verification:
Please check boxes for items that apply and give the amounts received during the past four consecutive weeks:

☐ Your Wages $ __________, __________.00
☐ Spouse’s Income $ __________, __________.00
☐ Self-Employment Income $ __________, __________.00
☐ Social Security Income $ __________, __________.00
☐ Unemployment/Income $ __________, __________.00
☐ Income from family or friends $ __________, __________.00
Financial Assistance Application

☐ Interest, dividends, rental income $________, ________.00
☐ Income from other sources $________, ________.00
Total gross income from all sources $________, ________.00

(Please complete and sign)

List dependent’s name and the date of birth:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Applying for Medicaid: Official use only Yes ☐ No ☐

Applying for Financial Assistance: Official use only Yes ☐ No ☐

Copies of supporting documents/forms must be returned with your application.

In most cases, determination on eligibility for financial assistance will be made within 10 business days of receipt of a completed Application (including all required supporting documentation). If your application has been approved, we will call you and schedule an appointment for you to come in to our office to sign the acceptance letter.

Please be informed that once your application is completed, you may disregard the hospital bills until the final determination is made. Once your application is approved, a new bill with the approved discounted amount will be sent to you. This application will only cover the hospital portion of the bills. If your financial situation changes for any reason, please do not hesitate to submit new information or re-apply.

Please read the following and sign below:

I represent that all statements on this form are true and correct and are made for the purpose of obtaining Financial Assistance from Beth Israel Medical Center or its affiliates. I authorize Beth Israel Medical Center to confirm the information provided on this form, including requesting credit information pertaining to my financial responsibility. I understand that false information provided on this form may result in denial of this Patient Financial Assistance Program Application.

Applicant Signature ___________________________ Date ______________

Financial Counselor ___________________________ Date Submitted ______________

Mail Completed Application to:
BIMC Patient Financial Counseling Department, 307 First Ave, New York, NY 10003