ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

ST. JOHN'S EPISCOPAL HOSPITAL

CHARITY CARE (ST JOHN'S CHOICE)
&
FINANCIAL ASSISTANCE PROCESS

(Revised August 2, 2017)

{ADDENDUM B}

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

CHARITY CARE AND FINANCIAL ASSISTANCE PROCESS
ST. JOHN'S CHOICE

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

OVERVIEW

SERVICE AREA FOR ST. JOHN'S EPISCOPAL HOSPITAL CHARITY CARE (ST JOHN'S CHOICE)

A. Everyone living in the five boroughs of New York City and Nassau County can get a discount on non-emergency, medically necessary services if they meet the income limits. No one will be denied medically necessary care because they are in need of financial assistance.

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

C. No charity care will be given for cosmetic surgery admissions or procedures that are not medically necessary.

D. Hospital will follow its **collection policy** on any outstanding balances after applicable charity care adjustments have been applied:
   a. An account may be referred to collection / bad debt if it meets one or more of the following criteria:
      i. Self pay balance not paid within 120 days after bill date when all reasonable follow-up efforts have been exhausted.
      ii. Patient/Guarantor advices Patient Accounts staff that they have no intention of paying the balance.
      iii. Patient communication via mail and/or telephone is unsuccessful due to bad information and/or is not responded to by patient/guarantor.
      iv. Patient fails to meet agreed payment plan, at which point the billing system moves the account to the next phase of billing in order to meet the required number of statements (four) prior to transfer to collection / bad debt.
   b. If a Self pay account that has been billed remains unpaid for over 120 days and all reasonable collection efforts have been exhausted, the account will be referred to bad debt. Reasonable collection efforts include:
      i. Sending an initial Self Pay bill (statement) for the balance and subsequent statements at 31 days, 61 days, and 91 days from bill date.
      ii. Reviewing previous accounts in the hospital's billing system to determine if a valid third party payer exists for the particular date-of-service.
      iii. Self pay "sweeps", via the established vendor, to determine Medicare and/or Medicaid eligibility as well as any managed care plans linked to said coverage.

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

PATIENT HANDOUT

ST JOHN'S CHOICE
CHARITY CARE AND FINANCIAL ASSISTANCE PROCESS OVERVIEW

The process to apply for charity care from St. John's Episcopal Hospital is as easy as A-B-C:

As part of our not-for-profit mission, St. John's Episcopal Hospital provides charity care to those who are unable to afford to pay for hospital care. Please contact our Patient Accounts Manager, or the assigned staff member in the department where you seek your care for information about the options available to help with your hospital bill. Confidential information and assistance including language translation services are available with advance arrangements.

A. Please arrange a visit with our Financial Counselors in the department where you seek your care.

B. Our Financial Counselors will confidentially review your situation to see if you qualify for some form of government or other financial assistance.

C. We will confidentially review your income and assets to determine your charity care requirements or whether other forms of assistance are available. If you cannot qualify for government assistance and we determine you qualify for charity hospital care, we will then provide you with a letter stating that all or part of your hospital care will be covered.

Please Note:

1. St. John's Episcopal Hospital can only provide charity hospital services. You must arrange for other health services (such as physician care, dental care, eyeglasses or prescription drugs) with individual doctors and other non-profit or government agencies for those services.
2. Upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility pursuant to the hospital's financial assistance policy, the patient may disregard any hospital bills* until the hospital has rendered a decision on the application.

*This note only applies to hospital bills (not physician bills, which you will have to address directly with the professional provider).

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

ST. JOHN'S CHOICE: CHARITY HOSPITAL CARE:
GUIDING PRINCIPLES OF UNDERSTANDING AND RESPONSIBILITIES

St. John's Episcopal Hospital's policy assures that patients receive medically necessary hospital services, regardless of their ability to pay. Physician services, outpatient medications and other non-hospital health services are not controlled by St. John's Episcopal Hospital, and therefore are outside our hospital's policy. It is recognized that St. John's Episcopal Hospital and other hospitals have limited abilities to absorb rising levels of free and under-reimbursed care. The patient shares a responsibility to work cooperatively with the hospital's billing office, insurers, and government agencies to reimburse the hospital for the services the patient receives. When payment funds are not available, the hospital shall inform a qualified patient that his or her bill has been forgiven.

The following points further clarify the principles of understanding regarding the hospital and patients shared responsibilities:

1. Having no insurance does not mean the person automatically qualifies for St. John's Choice. Similarly, having some level of coverage does not automatically preclude the hospital from discounting some or the entire uncovered portion of patient's bill as charity care.
2. The charity care application process will include an agreement by the applicant to cooperate with the hospital to pursue all appropriate funding options in a timely manner. Based upon a patient's circumstances, the options could include:

    - Medicaid/Medicare/Supplemental Security Income via Social Security Disability
    - Other entitlements
    - Assignments of any hospital services reimbursement received through other sources, lawsuits, etc.
    - Payment plans (monthly payments cannot exceed 10% of the patient's gross monthly income)
    - St. John's Choice charity care (full/partial)

3. The patient will agree to provide accurate information and respond quickly to calls or letters requesting required information.
4. The charity care application process shall be as streamlined as is feasible while providing a full consideration of income and assets available to cover the bill. Assistance will be provided by St. John's Episcopal Hospital to help patients complete any necessary forms. This shall include the assistance of a language translator should the need arise.
5. St. John's Episcopal Hospital's open door policy and St. John's Choice charity care application process shall be clearly posted in public areas and in admission materials.
6. Arrangements with physicians for their services are the responsibility of the patient.

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

Dear Patient:

Thank you for using St. John's Episcopal Hospital. It has been our privilege to be of service. Part of the mission of St. John's Episcopal Hospital is to deliver medical care to all persons in need, regardless of their ability to pay.

If you are unable to pay all or part of your hospital bill, our Financial Assistance Office will review your situation to determine if you qualify for government assistance, to establish a monthly payment plan or determine if you are eligible for Charity Care.

You should come to our Financial Assistance Office located in Room T5-33, first floor, during normal business hours (8:00 am to 4:00 pm). You may also call us at (718) 869-7077 or speak with the staff in the department where you are seeking care. Please advise the financial counselor if you need an interpreter. Before you come, please complete Section I of the enclosed *Application for Financial Assistance* form. Even if you cannot come to our Financial Assistance office, please complete Section I of the *Application for Financial Assistance* form and return it to the Hospital right away. The information will be used to determine if assistance is available for your Hospital bill. Forms may be obtained at the Registrar's desk in each Hospital service area. You may also request a copy of the form by calling (718) 869-7077 and we will mail it to you.

St. John's Episcopal Hospital works hard to provide high quality care and service to our community and beyond. You can be part of our efforts to provide quality care to everyone who comes through our doors by filling out the form and bringing it to the Financial Assistance Office.

Sincerely,

Bertrand Batista
AVP Revenue Cycle

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

Estimado/Estimada Paciente:

Gracias por utilizar los servicios de St. John's Episcopal Hospital. Ha sido para nosotros un privilegio de brindarle nuestros servicios. Parte de la misión de St. John's Episcopal Hospital es brindar atención médica a todas las personas, independientemente de su capacidad de pago.

Si usted no puede pagar la totalidad o parte de su cuenta hospitalaria, o parte de ella, nuestra Oficina de Asistencia Financiera analizará su situación para determinar si reúne las condiciones para recibir asistencia del gobierno, establecer un plan de pago mensual o determinar si es elegible para recibir cuidado caritativo.

Debe presentarse en nuestra oficina de Asistencia Financiera, ubicada en la Sala T5-33 de primer piso, en el horario de atención habitual (de 8:00am a 4:00 pm.). También puede llamarnos al (718) 869-7077 o hablar con el personal del departamento donde reciba atención. Por favor de informar al consejero financiero si necesita los servicios de un intérprete. Antes de presentarse, complete la Sección I del formulario adjunto denominado *Solicitud de Asistencia Financiera.* Si no puede acercarse a nuestra Oficina de Asistencia Financiera, complete de todos modos la Sección I de la *Solicitud de Asistencia Financiera* y envíe el formulario completo al hospital de inmediato. Esta información se utilizará para determinar si puede contar con asistencia para pagar su cuenta del hospital. Puede conseguir los formularios en el sector de admisiones de cada area de servicio del hospital. También puede solicitar una copia del formulario llamando al (718) 869-7077; le enviaremos la copia por correo.

St. John's Episcopal Hospital se esfuerza por brindar atención y servicios de excelente calidad a nuestra comunidad y a todas las personas. Usted puede sumarse a nuestros esfuerzos de brindar atención de calidad a todas las personas que atraviesan nuestras puertas si completa el formulario y lo entrega en la Oficina de *Asistencia* Financiera.

Atentamente,

Bertrand Batista
AVP Revenue Cycle

ST. JOHN'S CHOICE
CHARITY CARE OR FREE CARE POLICY PROCEDURE

General Guidelines:

St. John's Choice is a program where charity or free care is applied to medical care provided to low income, uninsured, or under-insured people by a hospital or other provider for which it does not expect to be paid.

St. John's Episcopal Hospital uses a consistent process to consider an individual's need for Charity Care based upon each patient's demonstration of inability to pay for their services or have their services covered by another payment source.

General guidelines are utilized which take into account a person's current outstanding and/or anticipated expenses for routine medical services at St. John's Episcopal Hospital, as well as the total service that the patient may require and the patient's potential resources that could be applied towards reimbursement for services.

St. John's Episcopal Hospital will assist patients in making a determination regarding whether or not the patient may be able to qualify for some form of entitlement through a governmental program. St. John's Episcopal Hospital will need the patient to assist in this determination and potential application process.

The application for St John's Choice is not and cannot serve as a substitute for existing government entitlement or other assistance programs. When it is determined that the patient has minimal resources and cannot qualify for assistance from any of the entitlement program, either 100% or partial charity will be granted. However, in the event that an individual has significant assets, the hospital may secure its interest in those assets as appropriate.

CRITERIA FOR DETERMINATION OF THE ST. JOHN'S CHOICE CHARITY AMOUNT

The criteria for determining the amount of charity care for which a patient is eligible at the time of an occasion or service should include the following factors:

1. Individual or family income
2. Individual or family net worth
3. Employment status
4. Family size
5. Other financial obligations
6. The amount and frequency of bills for health care
7. Other sources of payment for the services rendered

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

PROCESS OF THE ST. JOHN'S CHOICE: CHARITY APPLICATION

1. Staff will work with individuals, face to face or by letter, to gather the necessary information.

2. The applicant's eligibility for government assistance or entitlement programs will be reviewed; i.e., medical assistance (Medicaid/CHCEP) *(Catastrophic Health Care Emergency Program)*

3. The income chart contained in this guideline, disposable income computations, and the availability of other assets will all be used to help determine if the person qualifies for charity.

4. Charity care applications are reviewed by the Management and Supervisor in coordination with the Director of Patient Accounts to ensure consistency and continuity.

5. Generally, within 30 days of receipt of all necessary information, the Hospital will inform the applicant of any options that may exist for government assistance, payment plans, or charity care allowance. Once these options no longer exist, the Hospital will inform the applicant via letter or phone call of its charity decision.

INCOME GUIDELINES

In order to provide free care to individuals with income below 400% (FPG) of the federal poverty guidelines, the Hospital refers to the Base on Federal Poverty Guidelines (FPG) effective for the current year FPG change.

- For individuals having an income below 400% (FPG) of the federal poverty guideline and is in a household meeting the federal poverty guidelines, they may qualify to have their bill retracted off as charity when:

  - They are not able to qualify for any other assistance
  - They have cooperated in attempting to qualify
  - They do not have other resources to cover the bill

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

INFORMATION USED TO EVALUATE DETERMINATION OF CHARITY

In order to fairly administer these guidelines, applicants will be asked to provide and fill out a St. John's Choice Charity Care application (attached.) The patient will attest to the accuracy of the following information:

- Family size. Household composition.
- Gross monthly income of the household and from what sources.
- Reasonable monthly expenses of the household.
- Other resources/assets of the household
- St. John's staff will determine if the patients qualify for one of the assistance programs available in the community. Coverage considered will include, but not be limited to, Medicaid, Medicaid via SSI, County Assistance, CHCEP Program. St. John's staff will assist the patient in applying for these community programs.

OTHER ASSETS/RESOURCES

In considering other assets or resources which an individual might be able to apply to pay their bill, a review of the patient's assets will be conducted. However, St. John's Episcopal Hospital will not consider that the following assets/resources be liquidated in order to qualify for charity care. For patients with income levels of 150% or lower of the federal poverty guidelines, we will consider assets on a case-by-case basis

The following asset categories will always be exempt:

- Federally qualified personal retirement funds
- Sole residence
- Automobile(s) required to maintain family income
- Savings or similar assets (i.e.: CDs, stocks, etc.) with a value of less than two months of federal poverty guideline income

HHS FEDERAL POVERTY GUIDELINES 2017

Persons in family/household	Poverty guideline
For families/households with more than 8 persons, add $4,180 for each additional person.	
1	$12,060
2	16,240
3	20,420
4	24,600
5	28,780
6	32,960
7	37,140
8	41,320

https://www.gpo.gov/fdsys/pkg/FR-2017-01-31/pdf/2017-02076.pdf

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

Date:_____

_____

_____

_____

ADMISSION/SERVICE DATE: _____
ACCOUNT #:

_____

Dear Sir/Madam:

As per your request, attached is the form to be completed for participation in St. John's Choice charity care program. Please be sure to complete all questions on this form, sign it and return to us as soon as possible so that your application can be processed

If you have any questions feel free to call me at: (718)869-7077.

Return form to:

St. John's Episcopal Hospital
327 Beach19th Street
Far Rockaway, NY 11691
Attn: Patient Accounts
(718)869-7077

Thank you.

Very truly yours,

_____

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

Fecha:_____

_____

_____

_____

FECHA DE INGRESO O SERVICIO: _____
N° DE CUENTA:

_____

Estimado señor o señora:

De acuerdo con su solicitud, adjunto encontrará el formulario que debe llenar para consideración de atención de beneficencia. Asegúrese de responder todas las preguntas de este formulario y devuélvanoslo lo más pronto posible para la evaluación de la administración.

Devuélvalo a:

St. John's Episcopal Hospital
327 Beach19th Street
Far Rockaway, NY 11691
Attn: Patient Accounts
(718)869-7077

Gracias.

Atentamente,

_____

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

CHARITY CARE APPLICATION

Name _____ Telephone _____
Address _____
_____
Account Number _____
Medical Record Number _____

Dependents of Applicant (LIST YOURSELF FIRST)

Name(s)	Relation	Sex	DOB	Birthplace

If you or any member of the household is pregnant, list name _____ and due date_____

INCOME TYPE	AMOUNT	EXPENSE TYPE	AMOUNT
Salary (Net)	$	Child Support	$
Unemployment Benefits	$	Rent/Mortgage	$
Pension	$	Direct Purchase Health	$
Social Security	$	**Ins**	$
Annuity	$		$
Dividends/Interest	$		$
Rental Income	$		$
Alimony	$		$
Other Income	$		$
	$		$
SUBTOTAL INCOME	$	SUBTOTAL EXPENSE	$

NET INCOME CALCULATION (INCOME-EXPENSE)_____

CHARITY CARE CATEGORY (NET INCOME COMPARED TO ST JOHN'S SCALE AND POVERTY RATE)_____

I AFFIRM THAT THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Patient's Signature_____
Application completed by: _____Date: _____

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

APLICACIÓN DE SERVICISOS DE CARIDAD

Nombre del paciente _____Telefono_____
Dirección _____
Numero de cuenta _____
Numero de registro medico _____

Dependientes del Aplicante (primero su nombre)

Nombres	Relacion	Sexo	Cumpleaños	Lugar de Nacimiento

Si usted o un miembro en su familia esta embarazada, ponga el nombre aqui _____ y la fecha de parto_____

Tipo de Ingreso	Cantidad	Gastos	Cantidad
Salario Neto	$	Manutencion del niño	$
Beneficios de desempleo	$	Alquiler/Hipoteca	$
Pension	$	Compra directa de seguro medico	$
Seguro Medico.	$	Seguro	$
Pago de Seguro Social	$		$
Dividendo/Intereses	$		$
Alquiler	$		$
Alimonia	$		$
Otro Ingreso	$		$
SUBTOTAL INGRESO	$	SUBTOTAL GASTOS	$

Calculo de Ingreso Meto (INGRESOS-GASTOS)_____

CANTIDAD DE CUIDADO CARITATIVO (INGRESO NETO COMPARADO A LA ESCALA DE ST.JOHN'S Y A LA TASA DE POBREZA)_____

YO AFIRMO QUE LA INFORMACION PROVEIDA ES VERDADERA, COMPLETA Y CORRECTA A LO MEJOR DE MI CONOCIMIENTO.

Firma del paciente _____
Aplicación completada por: _____ Fecha: _____

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

INFORMATION USED TO EVALUATE DETERMINATION OF CHARITY CARE

In order to fairly administer Charity Care guidelines, applicants will be asked to provide and fill out the attached form. St. John's Episcopal Hospital will verify (when necessary) the following information:

- Types of services received or anticipated (i.e., is it a chronic condition that may qualify for other forms of government assistance or other significant expenses anticipated?)
- What is the family size?
- What is the gross monthly income of the household and from what sources?
- What are the reasonable monthly expenses of the household?
- What kind of other resources/assets does the household have?
- Can the patient quality for one of the assistance programs available in the community? (Coverage considered will include, but not be limited to, Medicaid, Medicaid via SSI, County Assistance, and CHCEP Program)

DOCUMENTATION REQUIRED FOR PROOF OF INCOME

Please submit one of the following documents to be reviewed for possible charity care:

- ☐ Income tax return, or if no return filed, letter from employer verifying income for last four (4) pay periods.
- ☐ Unemployment insurance stubs.
- ☐ Support payments divorce or separation.
- ☐ Retirement benefits, workers' compensation, pension.
- ☐ Letter of support from responsible party, with income documentation

Please be sure to complete all questions on both sides of this form and return it to us as soon as possible for management's review as follows:

St. John's Episcopal Hospital
327 Beach19th Street
Far Rockaway, NY 11691

Attention: Patient Accounts

Tel # (718)869-7077

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

INFORMACIÓN
USADA PARA EVALUAR LA DETERMINACIÓN DE ATENCIÓN DE BENEFICENCIA

Con el propósito de administrar de manera justa las pautas de atención de beneficencia, se pide a los solicitantes proporcionar y llenar el formulario adjunto. St. John's Episcopal Hospital verificará (cuando sea necesario) la siguiente información:

- Tipo de servicios recibidos o previstos (es decir, ¿es una enfermedad crónica que podría calificar para otras formas de ayuda gubernamental o se prevén otros gastos importantes?
- ¿Cuántos integrantes tiene la familia?
- ¿Cuál es el ingreso bruto mensual de los integrantes de la familia y cuáles son sus fuentes?
- ¿Cuáles son los gastos mensuales razonables de los integrantes de la familia?
- ¿Qué otra clase de recursos o activos tienen los integrantes de la familia?
- ¿Puede el paciente cumplir con los requisitos para alguno de los programas de ayuda con que cuenta la comunidad? (la cobertura considerada incluye, entre otros, Medicaid, Medicaid mediante el Ingreso suplementario del Seguro Social (SSI, por sus siglas en inglés), ayuda del condado, Programa de Gastos de Atención de Salud Catastrófica (CHCEP, por sus siglas en inglés).

DOCUMENTACIÓN EXIGIDA COMO COMPROBANTE DE INGRESO

Envíe uno de los siguientes documentos que se revisarán para una posible atención de beneficencia.

- ☐ Declaración de impuestos, o de no haberla presentado, carta del empleador que compruebe el ingreso de los últimos cuatro (4) períodos de pago.
- ☐ Talón de pago del seguro de desempleo.
- ☐ Pagos de manutención divorcio o separación
- ☐ Beneficios de jubilación, indemnización por accidentes y enfermedades laborales, pensión.
- ☐ Carta de respaldo de la parte responsable, con documentación de ingresos.

Asegúrese de responder todas las preguntas en ambas caras de este formulario y devuélvanoslo lo más pronto posible para la evaluación de la administración como se indica a continuación:

St. John's Episcopal Hospital
327 Beach19th Street
Far Rockaway, NY 11691

Attention: Patient Accounts

(718) 869-7077

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

NOTICE OF REDUCED FEE DETERMINATION

Date_____

Account Number_____

Patient's Last Name **Patient's First Name**

Guarantor's Last Name **Guarantor's First Name**

Guarantor's Address

Under St. John's Choice Charity Care policy, based on the income, family size and asset information provided, the patient listed above is eligible for a fee reduction as follows:

	Date(s) of Service	Original Charges	Reduced Amount	Patient Balance
Inpatient Admission				
Ambulatory Surgery				
Emergency Room				
Clinic Services				

If you have any questions regarding this fee reduction feel free to call us at (718) 869-7077.

Authorized by:_____

Payment due as follows:_____

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

ANUNCIO DE DETERMINACION DE TARIFA REDUCIDA

Fecha_____

Numero de cuenta _____

Apellido **Nombre**

Apellido del garante **Nombre del garante**

Direccion del garante

Bajo la Politica de seleccion de St.John's de cuidados caritativos, basado a sus ingresos, el tamaño de su familia y la informacion de pertenencias proveidas, el paciente mencionado anteriormente es elegible para una tarifa reducida de la siguiente manera:

(Seleccione todo lo que apliqué)				
	Fecha de Servicio	Cargos Originales	Cantidad Reducida	Nuevo Balance del paciente
Admisión del paciente Hospitalizado				
Cirugia Ambulatoria				
Cuarto de Emergencia				
Servicios de la Clinica				

Si usted tiene alguna pregunta respecto a esta tarifa reducida, por favor llamar al 718-869-5000

Autorizado por:_____

Los pagos se harian de la siguiente manera _____

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

NOTICE INCOME GUIDELINES EXCEEDED

DATE: _____ PATIENT'S NAME:_____

ADMISSION AND DISCHARGE DATE:_____

ACCOUNT:_____

AMOUNT DUE:$_____

As per your request, we have reviewed your account for consideration of Financial Aid/Charity Care. Based on the financial information that you have supplied, your income exceeds the limit to qualify for

Financial Aid/Charity Care, therefore, your obligation towards the amount due is $_____, which is payable to St. John's Episcopal Hospital room CP153. (718) 869-7077
Full payments is expected within 10 days from the date of this letter, or if you wish to make _____
Payments of $_____a month, please sign below.

DATE: _____ PATIENT'S SIGNTURE:_____

Method of payment:

( ) Cash	( ) Check	( ) Credit Card
( ) American Express	( ) Discover	( ) Master Card
( ) Visa		

ACCOUNT #_____EXPIRATION DATE:_____

CARD HOLDER'S NAME:_____ DATE:_____

If you disagree with this decision, Please submit a letter requesting reconsideration, the reason for request, and all documentation is support of your request. Your letter must be returned to St. John's Episcopal Hospital within 20 days of the date of this notice. You may also request a review by Department of Health (DOH) at 1-800-804-5447 or 518-402-6993.

We appreciate your prompt response.

Sincerely,

_____

ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

ANUNCIO INGRESO SOBREPASA EL LIMITE

FECHA: _____ NOMBRE:_____

FECHA DE ADMISION Y DE ALTA:_____

NUMERO DE CUENTA:_____

BALANCE:$_____

Basado en la información financiera que nos mando, sus entradas excede el límite para ser cualificado Por una cuenta de caridad. Por tanto su obligación es el balance de $_____el cual debe ser pagado a St. John's Episcopal Hospital de la siguiente manera: CP153. (718) 869-7077

Su pago completo debe ser recibió en 10 días de la fecha de esta carta.
O, si usted desea puede pagar en _____pagos de $_____ al mes, por favor firme si acepta estos pagos mensuales.

FECHA: _____FIRMA DE PAGO:_____

Método de pago:

( ) En efectivo	( ) Cheque	( ) Tarjeta de crédito
( ) American Express	( ) Discover	( ) Master Card
( ) Visa		

de su tarjeta/cuenta_____ Fecha de vencimiento_____

Firma Autorizada_____ Fecha_____

Si usted no está de acuerdo con la decisión, por favor de enviar una carta pidiendo una reconsideración. Incluya los documentos necesarios para apoyar su reconsideración. Tiene 20 dias para someter esta petición. También puede pedir al Departamento De Salud (DOH) que revise su caso al 1-800-804-5447 or 518-402-6993.

Agradecemos su repuesta lo más pronto posible.

Sinceramente,

_____