Montefiore | New Rochelle

Financial Assistance Summary

Montefiore Medical Center recognizes that there are times when patients in need of care will have difficulty paying for the services provided. Financial Aid 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 a Financial Counselor at 914-365-3812 or go to 16 Guion Place, New Rochelle, NY 10801 (Main Cashiers) for free, confidential assistance.

Who qualifies for a discount?

Financial Assistance is available for patients with limited incomes and no health insurance. Montefiore Medical Center also provides financial assistance to patients who have insurance coverage but have a large out-of-pocket expense that they cannot afford or deem a hardship, including payment arrangement upon request. Any financial aid allowance will be determined on a case-by-case basis.

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

Everyone who lives in New York State can get a discount on non-emergency, medically necessary services at Montefiore Medical Center if they meet the income limits. You cannot be denied medically necessary care because you need financial assistance.

You may apply for a discount regardless of immigration status.

What are the income limits?

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

2019	Gross Income Categories (Upper Limits)										
Federal Poverty Level	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Family Size	**100%**	**125%**	**150%**	**175%**	**185%**	**200%**	**250%**	**300%**	**400%**	**500%**	**over 500%**
1	$12,490	$15,613	$18,735	$21,858	$23,107	$24,980	$31,225	$37,470	$49,960	$62,450	$62,450
2	$16,910	$21,138	$25,365	$29,593	$31,284	$33,820	$42,275	$50,730	$67,640	$84,550	$84,550
3	$21,330	$26,663	$31,995	$37,328	$39,461	$42,660	$53,325	$63,990	$85,320	$106,650	$106,650
4	$25,750	$32,188	$38,625	$45,063	$47,638	$51,500	$64,375	$77,250	$103,000	$128,750	$128,750
5	$30,170	$37,713	$45,255	$52,798	$55,815	$60,340	$75,425	$90,510	$120,680	$150,850	$150,850
6	$34,590	$43,238	$51,885	$60,533	$63,992	$69,180	$86,475	$103,770	$138,360	$172,950	$172,950
7	$39,010	$48,763	$58,515	$68,268	$72,169	$78,020	$97,525	$117,030	$156,040	$195,050	$195,050
8	$43,430	$54,288	$65,145	$76,003	$80,346	$86,860	$108,575	$130,290	$173,720	$217,150	$217,150
For each additional person Add.	$4,420	$5,525	$6,630	$7,735	$8,177	$8,840	$11,050	$13,260	$17,680	$22,100	$22,100

* Based on the 2019 Federal Poverty Guidelines

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What if I do not meet the income limits?

If you cannot pay your bill, Montefiore Medical Center has a financial assistance category for all who apply. The percentage of the discount depends on your annual income and family size. We also offer extended payment plans and the monthly payment will not exceed ten percent of your monthly income.

Can someone explain the discount? Can someone help me apply?

Yes, free, confidential help is available. Call Financial Aid at 914-365-3812.

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 low-cost insurance, they will help you apply for a discount.

The Counselor will help you fill out all the forms and tell you what documents you need to bring.

What do I need to apply for a discount?

Acceptable proof of income:

- Unemployment statement
- Social Security/Pension Award letter
- Paystubs/Employment verification letter
- Letter of support
- Self-attestation letter (in appropriate circumstances)
- Tax Return

All medically necessary services provided by Montefiore Medical Center are covered by the discount. This includes outpatient services, emergency care, and inpatient admissions.

Charges from *private doctors* who provide services in the hospital may <u>not</u> be covered. You should talk to private doctors to see if they offer a discount or payment plan.

How much do I have to pay?

The amount for an outpatient service or the emergency room starts from $0 for children and pregnant women, depending on your income. The amount for outpatient service or the emergency room starts from $15 for adults, depending on your income.

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

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How do I get a discount?

You have to fill out the application form. As soon as we have proof of your income, we can process your application for a discount according to your income level. You will have 30 days to complete the application.

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.

Send the completed form to Montefiore New Rochelle-16 Guion Place, New Rochelle, NY 10801 Main Cashiers or you can bring it in in person to this office.

Once you have submitted a completed application and documentation, you may disregard any bills until the
hospital has rendered a decision on your application.

How will I know if I was approved for the discount?

Montefiore Medical Center will send you a letter within 30 days after completion and submission of documentation, telling you if you have been approved and the level of discount received.

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.

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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Attachment B
Application
FINANCIAL AID APPLICATION

APPLICANT INFORMATION							
Patient Name				Social Security Number			
Address				Application Date			
City		State		ZIP			
Phone		Relationship to Patient	**Self Spouse Child Parent Grandparent Grandchild Other**				
Gross Annual Income		Family Size		Balance Owed			

ELIGIBILITY WORKSHEET: FOR OFFICE USE ONLY					
Financial Counselor				Adjusted Account Balance	
Patient MRN		Account Number		Bill Reference Number	
IRS Verified Income	Yes No	Supporting Documentation	1. Paystub 2. Job Letter Other Specify:		
Verified Gross Annual Income					
The Applicant is approved for Financial Aid at the following category level (1-12)					
Application Request Date		IRS Tax Transcript Received Date			
Application Received Date		Account Adjusted Date			
Financial Aid Notification Date		Approval/Denial Date			
Approved by:					

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APPLICATION STATEMENT

My signature on this application reaffirms my authorizations for assignment of benefits and release of information related to medical services provided at Montefiore Medical Center.

While I am eligible for Financial Aid, I agree to inform Montefiore Medical Center of any changes in my family status in regard to family size, changes of income, and health coverage that could change my eligibility for Financial Aid. I authorize my employer and my health insurer to give Montefiore Medical Center information about income, health insurance premiums, coinsurance, co-payments, deductibles, and covered benefits that I have.

If I am seeking Financial Aid because of an accident or other incident and I receive money because of that accident or incident from any sources such as Worker's Compensation or an insurance carrier, I will repay Montefiore Medical Center for any medical services provided at Montefiore Medical Center and paid for or adjusted by Financial Aid.

All information in this application is true to the best of my knowledge and I agree to provide documentation upon request.

Patients Printed Name		Date	
Signature of Patient			

I am legally authorized to provide consent on behalf of the patient listed above. My relationship with the patient is described as follows:

Signature of Authorized Representative		Date	
Relationship to Patient			

Complete this application return to the following address:
Montefiore New Rochelle, Medicaid/Financial Aid 16 Guion Place, New Rochelle, NY 10801/Main Cashiers
Once you have submitted a completed application and documentation, you may disregard any bills until the hospital has rendered a decision on your application. Please complete application within 30 days.