HEALTH SOLUTION APPLICATION

A reduced-fee-for service program to ensure that all patients, regardless of their financial situation, can access affordable services at

Andrus Pavilion
ParkCare Pavilion
Yonkers, New York
and
Dobbs Ferry Pavilion
Dobbs Ferry, New York

If you have any questions regarding this application, please call (914) 964-7799, a financial counselor will be happy to assist you.
OVERVIEW OF HEALTH SOLUTION

Riverside Health Care System, Inc. recognizes that its mission is to provide medical care to all persons in need regardless of their ability to pay and will not discriminate against a patient on the basis of his/her ability to pay for non-elective procedures.

To assist uninsured patients who are unable to pay their medical bill, Riverside Health Care System, Inc. has developed the Health Solution program. Health Solution is not an insurance plan, but rather a discounted fee-for-service program. This means that upon accessing the program, Riverside Health Care member organizations will provide health services to you at a discounted rate. The level of the discount a person receives is based upon individual financial information. Health Solution only applies to services provided by St. John’s Riverside Hospital-Andrus Pavilion, Park Care Pavilion and Dobbs Ferry Pavilion, it does not cover physician fees.

The organization encourages patient’s to apply for the Health Solution program prior to obtaining services at St. John’s Riverside Hospital-Andrus Pavilion, Dobbs Ferry Pavilion and Park Care Pavilion. However, the organization understands that many medical visits, especially visits to the Emergency Department are unpredictable. Therefore, the organization allows patients to apply for Health Solution up to 120 DAYS after a service was rendered. Health Solution only applies to unpaid fees.

If you would like to participate in the Health Solution Program please complete this Health Solution Application and return it to a Financial Counselor. If you have any additional questions regarding Health Solution, please contact a Financial Counselor at (914) 964-7799, she will be happy to assist you.

Once a patient has submitted a completed Health Solution Application the patient may disregard any bill that might be sent until the organization has made a decision on the application.

INSTRUCTIONS FOR COMPLETING THE HEALTH SOLUTION APPLICATION

INSTRUCTIONS FOR COMPLETING THE HEALTH SOLUTION APPLICATION. This application is only valid for services rendered at St. John’s Riverside Hospital-Andrus Pavilion, Dobbs Ferry Pavilion, and Park Care Pavilion.

PLEASE READ the entire application, instructions and document checklist on page 8 before you fill out the application. Applicants must complete all sections and provide all necessary documents. Incomplete applications will not be processed.

Be assured that the organization’s financial services are 100% confidential! Your financial information and citizenship status will not be disclosed to anyone without your permission. If you have any concerns regarding the confidentiality of your information, please contact a Financial Counselor at (914) 964-7799.

SECTION A – CONTACT INFORMATION
In this section, we ask for information about how to contact the patient and the applicant. The home address is where the person applying for Health Solution lives. The mailing address, if different, is where the Health Solution card and all notices will be sent. If the patient does not have a Social Security number, please leave that space blank.

SECTION B – HEALTH INSURANCE
It is important to tell us whether you have health insurance; it helps us determine the amount of assistance covered by Health Solution.

SECTION C – HOUSEHOLD INFORMATION
List the names of all the people who live in the patient’s household and the patient is financially responsible for. Listing the household members may allow us to give you a lower fee level.

SECTION D – PATIENT’S INCOME
In this section, list all types of income and the amount received by the patient and the patient’s spouse.

If there is no money coming into the household, explain how the patient is being supported.

SECTION E – PATIENT’S RESOURCES
List all of the patient’s resources. This allows us to assess the level of assistance available to you.

SECTION F – PATIENT RELEASE OF INFORMATION AND AUTHORIZATION TO PROCESS APPLICATION
By reading and signing this statement, you state that you understand your responsibilities under Health Solution and give St. John’s Riverside Hospital the authority to process this application.
### Section A - CONTACT INFORMATION:

Please tell us who you are and how to reach you.

<table>
<thead>
<tr>
<th>Date of Service or Admission:</th>
<th>Date of Application:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle Initial:</th>
<th>Last Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SS#:</th>
<th>Primary Language Spoken:</th>
<th>Date of Birth:</th>
</tr>
</thead>
</table>

Please give us a number where you can be reached if we need to contact you for more information.

<table>
<thead>
<tr>
<th>Phone #:</th>
<th>Another Phone #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Address of Patient/Applicant</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street:</th>
<th>Apt. #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
<th>County:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mailing Address of Patient/Applicant</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street:</th>
<th>Apt. #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
<th>County:</th>
</tr>
</thead>
</table>

At which Riverside site do you receive health services? (Check all that apply)

- □ Andrus Pavilion
- □ Park Care Pavilion
- □ Dobbs Ferry Pavilion

Only fill out this section if the person filling out the application is NOT the patient.

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle Initial:</th>
<th>Last Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street:</th>
<th>Apt. #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
<th>County:</th>
</tr>
</thead>
</table>

Relationship to Patient: [] Spouse  [] Child  [] Grandparent  [] Grand Child  [] Other

If you are completing this application for someone under the age of 18, please call a Financial Counselor at (914) 964-7799.

### Section B – PATIENT’S or APPLICANT’S HEALTH INSURANCE INFORMATION:

You may still be eligible if you have health insurance.

Do you currently have health insurance? [ ] Yes  [ ] No

If yes please provide us with the following information:

<table>
<thead>
<tr>
<th>Primary Insurance:</th>
<th>Identification Number:</th>
<th>Policy Holder’s Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Secondary Insurance:</th>
<th>Identification Number:</th>
<th>Policy Holder’s Name:</th>
</tr>
</thead>
</table>
# Health Solution Application

## Section C – PATIENT’S or APPLICANT’S HOUSEHOLD INFORMATION:
List the names of all persons who live in your household. Examples of household members are: parents and children.

<table>
<thead>
<tr>
<th>Name of Each Household Member (First, Middle, Last)</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>
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<tr>
<td>3.</td>
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<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>

## Section D – PATIENT’S or APPLICANT’S INCOME:
List patient’s and the patient’s spouse’s type of income and the amount received in the spaces below. Fill in all that apply.

<table>
<thead>
<tr>
<th>Categories of Income</th>
<th>Type of income/employer name</th>
<th>How much does the person receive? (before taxes)</th>
<th>How often is the income received (weekly, every two weeks, monthly, other)</th>
<th>Annual Income (to be filled out by staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples</strong></td>
<td>wages/ XYZ Company</td>
<td>$350</td>
<td>weekly</td>
<td>$18, 200</td>
</tr>
</tbody>
</table>

**Earning from work:**
Types of income: wages, salaries, commissions, tips, overtime, self employment

**Unearned income:**
Types of unearned income: Social Security Benefits, disability payments, unemployment payments, interest and dividends, veteran’s benefits, worker’s compensation, child support payments/ alimony, rental income.

**Contributions:**
Types of contributions: Money from relatives or friends, roomers, boarders (Include money that anyone gives you each month to help meet living expenses)

**Other:**
Temporary (cash) Assistance or Supplemental Security Income (SSI) payments, student grants or loans.

Total Annual Income: (to be filled by staff)

If no income, please explain (for example, living with friend or relative):
ASSIGNMENT OF RIGHTS

I authorize my employer and my health insurer to give to this organization information about income, health insurance premiums, coinsurance, co-payments, deductibles, and covered benefits that I have.

If I am seeking to become a member of Health Solution because of an accident or other incident, and I receive money because of that incident from any sources, such as workers’ compensation or an insurance carrier, I will repay the organization for any medical services paid by those payers. I give the organization the right to collect payments from insurers for medical care as appropriate.

While I am eligible for Health Solution, I agree to tell the organization of any changes in my family status including family size, income changes, and health insurance coverage, which could change my eligibility.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. **I understand that the organization cannot share confidential information, such as the information contained in this application, with any state or federal agency, except as stated above, without my prior approval.**

_________________________                      ________________
Signature of applicant                             Date

*If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.*

_________________________                      ________________
Signature of authorized representative             Date

If not signed, is Assignment of Rights attached?  ☐ Yes  ☐ No
Upon completion of your Health Solution Application a Financial Counselor will complete the form below, review your application and contact you to inform you of the results of your Health Solution Application.

It is important that you retain the bottom portion of this form and refer to it when asking about your Health Solution Application. If you have any questions regarding your application, please call (914) 964-7799. Someone will be happy to assist you.

| Patient’s Name: _________________________________________________________ |
| Applicant’s Name if different from patient: ___________________________________ |
| Date Application Completed: ______________________________________________ |
| Application Reference #: _________________________________________________ |
| Name of staff member who assisted with application: __________________________ |
| Signature of Financial Counselor who received/processed application: X __________________________________________________________ |

Health Solution — Application Receipt
**DATE OF BIRTH:**
You must show ONE of the documents listed.

- Drivers License/ Official Photo Identification
- Passport
- Birth Certificate
- Baptismal/ Other Religious Certificate
- Official School Records

**PROOF OF IDENTITY**

- Government Issued Photo Identification
- Driver’s license or Passport

**PROOF OF HOME ADDRESS**
You must show ONE of the documents listed.

(This must match the home address in Section A, and the proof must be dated within 6 months of the application)

- ID Card with address
- Postmarked envelope, postcard, or magazine label with name and date. (cannot use if sent to a P.O. Box)
- Driver’s license
- Utility bill (gas, electric, cable), or correspondence from a government agency which contains name and street address.
- Letter/ Lease/Rent Receipt with home address from landlord
- Property tax records or mortgage statement

**DEPENDENT CARE COSTS:** If applicable, you must show ONE of the documents listed.

- Written statement from day care center or other child/ adult care provider
- Canceled checks or receipts

**PROOF OF CURRENT INCOME:**
Submit ONE from all of the categories that apply to you.

*Note: You must provide a letter, written statement, or copy of check stubs, from the employer, person or agency providing the income. Provide the most recent proof of income before taxes. The proof must be dated, include the employee’s name and show gross income for the pay period.*

- **WAGES AND SALARY**
  - Paycheck stubs (2 consecutive weeks)
  - Letter from employer on company letterhead, signed and dated
  - Income tax return/W-2 of previous year*
  - Business records
- **SELF EMPLOYMENT**
  - Signed and dated income tax return and all schedules*
  - Records of earnings and expenses

- **PRIVATE PENSIONS/ ANNUITIES**
  - Statement from pension/annuity

- **SOCIAL SECURITY**
  - Award Letter/certificate
  - Benefit check
  - Correspondence from Social Security Administration

- **CHILD SUPPORT/ALIMONY**
  - Letter from person providing support
  - Letter from court
  - Child support/ alimony check stub

- **WORKER’S COMPENSATION**
  - Award letter
  - Check stub

- **VETERAN’S BENEFITS**
  - Award letter
  - Benefit check
  - Correspondence from Veterans Administration

- **MILITARY PAY**
  - Award letter
  - Check stub

- **INTEREST/DIVIDENDS/ ROYALTIES**
  - Statement from bank, credit union or financial institution
  - Letter from broker
  - Letter from agent

- **INCOME FROM RENT OR ROOM/BOARD**
  - Letter from roomer, boarder, tenant
  - Check stub

- **SUPPORT FROM OTHER FAMILY MEMBERS**
  - Signed statement or letter from family member

* W-2s or income tax returns for other than self-employed may be used for applications prior to April of the following year. If later you must include another form of documentation.