Long Island
Community Hospital

CHARITY CARE PROGRAM APPLICATION

LONG ISLAND COMMUNITY HOSPITAL
Patient Financial Services Department
101 Hospital Road, Patchogue, NY 11772
Telephone: 631-654-7130 & 631-654-7140

Part A: (to be completed by applicant) **Date of Application: _____**

Applicant Name: _____ **Patient Name: _____**

Address: _____ **Account #: _____**

_____ **Date of Service: _____**

Phone #: _____ **Family Size: _____**

Annual Patient/Family Income:

Salary & Wages: $_____

Other Income: $_____

Total: $_____

(MUST ATTACH COPIES OF PROOF OF INCOME)

"I certify that the preceding information is true and correct"

_____
Applicant's Signature (if other than Patient, state Relationship)

_____

Part B: (to be completed by Hospital) **Date Application Received: _____**

DECISION:
( ) Application Approved for Free Care

( ) Application Approved for Financial Assistance – Discount of _____%

( ) Application Pended: _____

( ) APPLICATION DENIED
Reason ( ) Income Exceeds amount required for eligibility
( ) Information requested has not been received

( ) Other _____

Type of Service: ( ) In-Patient ( ) Out-Patient

Account #: _____

Date of Service: _____ **Total Charges: $_____**

Patient Responsibility: $_____ **Charity Care Allowance: $_____**
****If you default on your payment your account(s) will be reviewed for referral to a Collection Agency****

_____
Hospital Representative Signature – Date

***If you wish to appeal this decision Please contact the Patient Financial Services Department at 631-654-7140**