

**Mother Bernardina Charity Care  
St. Elizabeth Medical Center  
2209 Genesee Street Utica, New York 13501**

Date of Request \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Applicant's SS Number \_\_\_\_\_

Mother Bernardina Charity Care Requested By: \_\_\_\_\_

Size of Family Unit: \_\_\_\_\_ (Number of dependants listed on Income tax Return)

Family Income last 12 months: \$ \_\_\_\_\_  
Is Patient a dependent on any additional tax forms? Yes  No   
If yes, please attach copy of income Tax Return

Proof of current Income Enclosed\*: **Federal Tax Return (Required)** \_\_\_\_\_ W2 \_\_\_\_\_ Social Security(SSA1099 Benefit Summary) \_\_\_\_\_ Notarized Statement \_\_\_\_\_

**Please call with any questions**

**\*Additional Financial Documentation May Be Requested**

Please detail any changes in family circumstances or income for the past 6 months prior to the date of this application and any expected change in the 6 months following this application.

To apply for the Mother Bernardina Charity Care Program, please complete the application form. We will require adequate documentation as to your family level (most recent income tax return and W-2's for each working member). **If you are requested to apply for Medicaid, you must do so prior to us giving consideration to your application. The Business Office will make a final written determination of eligibility within 30 working days after receiving the completed application and all required documentation. Questions will be answered by calling the Business Office at 315-734-3108.**

I understand that the information, which I submit, is subject to verification by St. Elizabeth Medical Center and its Internal Auditors. I certify that the above information is true and correct.

\_\_\_\_\_  
Signature of Person making request

***Do Not Complete \* Medical Center Use Only***

This document was received on \_\_\_\_\_ by \_\_\_\_\_

Documents Received for verification: W-2's \_\_\_\_\_ Pay Stubs \_\_\_\_\_ Other \_\_\_\_\_

Verification Information was received on \_\_\_\_\_

Date Application Approved \_\_\_\_\_

Admit -14  
Rev. 1/12

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ISO 9001, 14001 – Certified  
National Integrated Accreditation for Healthcare Organizations - Accredited

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Utica, New York 13501**

**ST. ELIZABETH MEDICAL CENTER MISSION STATEMENT**

The St. Elizabeth Medical Center community, inspired by St. Francis of Assisi and faithful to the teachings of the Roman Catholic Church, is committed to excellence in healthcare and education. We pledge to do this with compassion and respect for the dignity of all.

**Notice of Availability – Mother Bernardina Charity Care Program**

To support our Mission, St. Elizabeth Medical Center has developed the Mother Bernardina Charity Care Program effective January 1, 2003. The Medical Center will make available a reasonable amount of uncompensated services to eligible persons. **This program is limited to services billed by St. Elizabeth Medical Center.** Patient eligibility for the Mother Bernardina Charity Care Program is determined by measuring family income against the income poverty guidelines established by the Department of Health and Human Services. These income levels are adjusted annually to comply with similar annual increases to the poverty guidelines. Tier 1 levels are paid in full, Tier 2 and 3 levels require a minimal cost share per account.

**\* Bad Debt accounts in Legal are not eligible for inclusion in Charity Care. Accounts that have been turned over to a Collection Agency within the past 12 months will be considered \***

**Poverty Income Guidelines for Mother Bernardina Charity Care**

<u>Size of Family Unit</u>	<u>Tier 1 Family Income</u>	<u>Tier 2 Family Income</u>	<u>Tier 3 Family Income</u>
1	\$12,600 - \$17,700	\$17,701 - \$22,150	\$22,151 - \$25,150
2	\$16,900 - \$23,900	\$23,901 - \$28,500	\$28,501 - \$33,900
3	\$21,320 - \$30,200	\$30,201 - \$36,200	\$36,201 - \$42,600
4	\$25,600 - \$36,200	\$36,201 - \$43,100	\$43,101 - \$51,200
5	\$30,100 - \$42,400	\$42,401 - \$52,600	\$52,601 - \$60,000
6	\$34,400 - \$50,000	\$50,001 - \$60,300	\$60,301 - \$68,600
7	\$38,800 - \$56,700	\$56,701 - \$67,200	\$67,201 - \$77,300
8	\$43,100 - \$63,600	\$63,601 - \$74,500	\$74,501 - \$86,000

**COST SHARE PER EACH ACCOUNT**

Inpatient and ASU	\$0	\$200	\$400
Emergency Room and Other	\$0	\$70	\$150
Clinic	\$0	\$20	\$30

For family units with more than 8 members, add \$3,820.00 for each additional member.

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