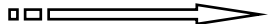


AVAILABILITY OF FREE OR REDUCED COST CARE

We are here to help you. To be considered for our Charity Care Program, **you must be uninsured or underinsured and have a letter of denial from Medicaid.** You will then need to fill out an application. It's important to file an application for Charity Care before, or as soon as possible after you receive services here at WCA Hospital.

- Please note that any accounts transferred to a collection agency prior to completing an application will not be eligible for the Charity Care Program.
- You must make an application for Free Care or reduced cost care within **120 days** from the date you receive your first bill for services at WCA Hospital.
- In most cases, physician professional service fees are not included as part of WCA Hospital's Charity Care Program.
- To be eligible, your family or household income must be at or below 3 times the poverty guidelines as published by the Department of Health and Human Services. Guidelines are updated once each year. (see chart)

2006 POVERTY GUIDELINES* Department of Health and Human Services



Once we have received a **complete** application:

- All outstanding bills with the applicant's social security number will be placed on hold until the completed application is processed by Patient Financial Services.
- We will mail you a letter of eligibility approval or denial. If you apply prior to receiving our service, a decision on your eligibility will be made within one week. We will respond to all other applications within 30 days.
- At times, you may be asked to fill out a new application as your financial situation may change.

Family Size	US except Alaska and Hawaii	WCA Charity up to 300%
1	\$9,800	\$29,400
2	\$13,200	\$39,600
3	\$16,600	\$49,800
4	\$20,000	\$60,000
5	\$23,400	\$70,200
6	\$26,800	\$80,400
7	\$30,200	\$90,600
8	\$33,600	\$100,800
Each additional person	\$3,400	\$10,200

Source: Federal Register, Vol 71, No. 15
January 24, 2006, pp.3848-3849.

*Rates are updated once a year and are subject to change

APPLICATION FOR CHARITY CARE

For an application to be processed it must include these four steps:

1. Gather all the documentation in Part 1 (this must be included with the application)
2. Answer all the questions in Part 2
3. Be sure to fill in the date on Part 1 and sign your name to Part 2 with the request date.
4. Return all the documentation and the completed application by mail or in person to:

Customer Service/Finance Department or
WCA Hospital
207 Foote Avenue
PO Box 840
Jamestown, NY 14702-0840

Jamestown Family Health Center
Panama Health Center
Sinclairville Health Center
Randolph Health Center
Dunkirk Health Center

Part 1

Date: _____

Documentation: Proof Of Total Gross Household Income (All Occupants)
Please include all that apply: (more than one type of earnings may apply)

- ◇ Pay or income stubs for the last 12 weeks.
- ◇ Statement from your employer of gross earnings for last 12 weeks
- ◇ Statement of unemployment compensation benefits
- ◇ Statement of child support earnings
- ◇ Statement of disability income
- ◇ Profit/loss statement (if self-employed)
- ◇ Copy of Tax Return- most recent
- ◇ Denial of coverage for services from any insurance company
- ◇ Letter of decision from Medicaid

(complete back page)

Incomplete applications will not be processed and will be returned to the sender.

APPLICATION FOR FREE or REDUCED-COST CARE (Part 2)

I hereby request that WCA Hospital make a written determination of my eligibility for Free or Reduced-cost Care at WCA Hospital. I understand that the information, which I submit, is subject to verification by the WCA Hospital Finance Department. I also understand that if the information that I submit is determined to be untrue, or in any way falsified, the hospital may re-evaluate the status of my eligibility and take whatever action is appropriate.

Patient Name(s) _____ Age(s) _____

Responsible Party (if other than patient) _____

Address _____

Telephone (Home) _____ (Work) _____

Employer (Patient) _____

Employer (Responsible Party) _____

Insurance Coverage(s) _____

Type of service given or being requested for future _____

Applicant's Social Security # _____

HOUSEHOLD INCOME: (include all occupants)	Total Last 3 months (gross amount)	Total Last 12 months (gross amount)
Wages/Income	_____	_____
Self-Employment Income	_____	_____
Unemployment	_____	_____
Compensation	_____	_____
Social Security	_____	_____
Public Assistance	_____	_____
Child Support	_____	_____
Pension Income	_____	_____
Rental Income	_____	_____
Other (Please Specify)	_____	_____
Family Size _____		

(On income tax documents)

Family Members (List)	Name	Relationship
	_____	_____
	_____	_____
	_____	_____

Date of Request: _____ Applicant's Signature: _____

For Financial Counseling

Please call **716-664-8360**

or
Customer Service Call Center
716 - 664 - 8216

or
stop by
WCA Hospital Cashier's Office
207 Foote Avenue
Jamestown, NY 14701

MEDICAID

A program that provides assistance with payment of medically necessary healthcare services for limited income individuals and families.

Contact our local office:

Chautauqua County Department of
Social Services
110 East 4th Street
Jamestown, N.Y. 14701
PHONE: 716-661-8246

WCA Hospital Charity Care Program Application

Free or Reduced-cost Care

*WCA Hospital,
including all its locations,
is committed to providing its
services without charge
to eligible persons
who cannot afford
to pay for care.*



