Bronx Campus:
1740 Eastchester Road, Bronx, NY 10461

Brooklyn Campus:
150 55th Street, Brooklyn, NY 11220

FINANCIAL AGREEMENT

I. Request for Admission. I, as the patient (the "Patient") request admission to, and/or I, as the guarantor (the "Guarantor") request that the Patient be admitted to, Calvary Hospital (the "Hospital").

II. Guarantee of Payment.

The Hospital will be providing hospital and medical care to the Patient. If any insurance coverage that the Patient may have (***Medicare, Medicaid, Blue Cross or other Commercial Insurance including HMO's***) either rejects the billing claim or allows only part of the claim, the Patient does not have insurance coverage, and/or the insurance coverage is exhausted during the Patient's hospitalization, I, as Patient and/or Guarantor, shall be fully responsible for payment of the Patient's hospital bill, ***with the Patient's resources***, based upon the Hospital's posted charges, which I agree are fair and reasonable, a room & board rate of **$2,050 per day** ***plus*** ancillary services and supplies ***plus*** *a* 9.63% *New York State Indigent Care Pool Surcharge*.

Calvary Hospital's website (www.calvaryhospital.org) can also provide additional information links for the following:

- Financial assistance policy
- Policy on viewing Calvary Hospital charges
- Insurance Plans that Calvary Hospital participates
- Physician (employed and consulting) insurance participation

III. Cooperation in Completing Insurance Coverage Forms and Medicaid Application. I, as Patient and/or Guarantor, have been advised of the Patient's responsibilities as specified within the Medicaid guidelines. I, as Patient and/or Guarantor, shall cooperate with the Hospital by furnishing information and by signing appropriate documents in order to apply for insurance coverage and/or Medicaid.

IV. Understanding this Agreement. I have read and do understand this Agreement. A copy has been provided for my retention.

Patient Name	Name of Guarantor (Print)
Signature of Patient	Signature of Guarantor
	Street Address
Witness	City, State, Zip
Date	Telephone Number

MEDICARE

GENERAL EXPLANATION OF MEDICARE BENEFITS FOR 2022

PART A – DEDUCTIBLE AND CO-INSURANCE AMOUNTS

TIME LIMITATION	INPATIENT HOSPITALIZATION	PATIENT RESPONSIBILITY (or supplemental insurance if available)
First 60 days	Full Days) (Full Medicare Coverage After Deductible	**$1,556** (each benefit period)*
61st thru 90th Day	Co-insurance Days (Partial Medicare Coverage)	**$389** (per day) Always equal to ¼ of hospital deductible
91st thru 150th Day	Lifetime Reserve Days (Partial Medicare Coverage) (60 days nonrenewable)	**$778** (per day) Always equal to ½ of hospital deductible

PART B – DEDUCTIBLE AND CO-INSURANCE AMOUNTS

	PHYSICIAN'S SERVICES	
No Time Limit	Deductible	**$233** (once per year)
No Time Limit	Co-insurance (20% of "Medicare Approved Charge")	**$15** (approx.) per visit

* A "benefit period" (also called "spell of illness") is a period of consecutive days that begins with a hospitalization and ends when the patient has not been an inpatient of a hospital or a skilled nursing facility for 60 consecutive days. A beneficiary can have more than one benefit period per year.

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

I hereby authorize and direct the above named Medical facility, having treated me to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representative thereof to examine and make copies of all records relating to care and treatment. I also authorize Calvary Hospital to bill on behalf of the above mentioned patient if the patient is no longer here at the time of the billing.

Date__________ Signature of Patient or Authorized Representative____________________________

I hereby assign, transfer, and set over to the above named Medical facility sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said hospital.

Date__________ Signature of Patient or Authorized Representative____________________________

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given to me in applying for payment under title XVIII of the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Date__________ Signature of Patient or Authorized Representative____________________________

MEDICARE "60 DAYS" FORM

Medicare will pay an additional 60 days of hospital care subject to a **$778.00** daily co-insurance payment for which you are responsible. The 60 days are a lifetime maximum and once payment is made, the 60-day reserve will be permanently reduced by the days used. Do you wish to have payment under the provision for your present hospital stay?

Yes______ No_______

Date _____________ Signed ________________________________ ____________________________
Relationship to Patient

OFFICIAL DOCUMENT FOR PATIENTS/FAMILY MEMBERS REGARDING ACCESS TO END OF LIFE CARE

This document should be read, signed and given to a family member/ patient representative upon admission of a patient to Calvary Hospital when traditional Medicare or Medicaid plan is not their primary health insurance.

Under a new State law (effective January 1, 2000)
For Commercial HMO (excluding ERISA self funded plans) & Medicaid Managed Care Plans

- If the patient's physician certifies that the patient has a diagnosis of advanced cancer with no hope of reversal of primary disease and less than sixty days to live; and
- If the patient's physician, in consultation with the Medical Director of Calvary Hospital, determines that the patient's care would be appropriately provided by Calvary Hospital; and
- If the patient and/or patient's family request that the patient be admitted to and treated at Calvary Hospital; and
- If the patient's health care plan provides benefits for hospital and medical care, including coverage for acute services

The patient's health care plan ***must*** provide coverage for acute care services provided to the patient at Calvary Hospital, including coverage for the admission, provision and/or continuation of care of the patient as long as the continued stay is determined to be medically appropriate by Calvary's Medical Director.

I have been advised that Calvary Hospital's reimbursement from the patient's insurer under the 'End of Life care' law will not allow Calvary to seek additional reimbursement from the patient except to collect any copayment, coinsurance or visit fees, or deductibles for which the patient is responsible under the terms of their applicable health plan.

However, if it is determined that continued stay is no longer appropriate, Calvary's Clinical Review/Case Management department will contact you to make arrangements for a transfer. If you have additional questions, please contact Clinical Review/Case Management Department, at (718) 518-2000 x2258.

In the event that the patient/family refuses an appropriate transfer, the patient/family shall be fully responsible for payment of the patient's hospital bill, ***with the patient's resources***, based upon the Hospital's posted charges, which the patient/family agree are fair and reasonable, at the room & board rate of **$2,050 per day** ***plus*** ancillary services and supplies ***plus a 9.63%*** *New York State Indigent Care Pool Surcharge.*

I have read and do understand the above. A copy has been provided for my retention.

Patient Representative Signature	Witness (Calvary Hospital)
Patient Name	Date

PATIENT SPECIFIC CONTRACT AGREEMENT

This letter confirms an agreement between Calvary Hospital, Inc. **(Provider)** and

____

[Name of insurance company] **(Insurer)**

____

[Address of insurance company]

____

for the provision of Inpatient Hospital Services by Calvary Hospital to a covered person **(Member)** of the aforementioned insurance company:

Member's Name: ____

Member's Identification Number: ____

Member's Date of Birth: ____

Insurer Referral/Authorization Number: ____

Effective Date (date of admission): ____

For inpatient hospital facility services rendered to **Member** listed above **Provider** agrees to accept as payment in full from the **Insurer**, discounted to $1,650 inpatient per diem less any co-payments, coinsurance and/or deductible due from **Member**. Physician services are excluded.

The insurer will be responsible to pay, in addition to the aforementioned, the Statutory New York State Indigent Care Pool Surcharge as applicable.

The discount from published charges is in consideration of the **Insurer** accepting the **Provider** utilization review departments clinical assessment decisions and in consideration of payment of the agreed upon amount within 45 days of receipt of billing for services rendered by **Provider**.

Definition: All-inclusive per diem reimbursement rates include all Hospital and physician services rendered to **Member** by **Provider.**

By signing below, as an authorized representative**,** I agree to all of the terms and conditions outlined in this letter of agreement**.**

Date:	______________________	Date:	______________________
Name:	______________________	Name:	______________________
Signature:	______________________	Signature:	______________________
Title:	______________________	Title:	______________________
	Provider Representative		**Insurer Representative**

Kindly return the signed Patient Specific Contract Agreement to the Outreach Services Department via fax at (718) 518-2670. Their telephone number is (718) 518–2000 x2300.

The terms in this Patient Specific Contract Agreement are not negotiable.

Noncovered Continued Stay

____
Name of Patient or Representative

The purpose of this notice is to inform you that we believe your continued hospital stay will not be paid due to lack of medical necessity.

We believe that beginning on ______________________ you will be responsible for payment of your continued stay at a room & board rate of **$2,050** per day plus ancillary services and supplies plus a 9.63% *New York State Indigent Care Pool Surcharge*.

Your signature below indicates that you will be liable for the cost of the services as indicated above. You will receive a copy of this notice.

____ ______________________________________

Signature of Beneficiary or Representative | Date

____ ______________________________________

Witness | Date