CALVARY HOSPITAL
Where Life Continues

Financial Assistance Summary

Calvary Hospital recognizes that there are times when patients in need of care will have difficulty paying for the services provided. The Hospital provides discounts to qualifying individuals based on income. Calvary Hospital will provide emergency medical care within the guidelines of the Rapid Response Policy (see Nursing policy B.19 Rapid Response) without discrimination, whether or not the individuals are FAP eligible.
Just contact our Patient Accounts Department at 718-518-2048 for a Financial Assistance application: An application can also be found on the hospital's website by visiting: www.CalvaryHospital.org/admissions/patientfinancialinformation.

Who qualifies for a discount?
Financial assistance is available for patients with limited incomes who have no health insurance or have exhausted their health insurance benefits.
Every New York State resident who needs medically necessary services at Calvary Hospital can get a discount if they meet the income limits. You cannot be denied medically necessary care because you need financial assistance.

What are the income limits?
The amount of the discount varies based on your income and the size of your family. If you have no health insurance, have exhausted your insurance benefits, or have incurred deductibles, co-pays or coinsurance, these are the income limits:

Size of Family	400% Annual Poverty Income Guidelines
1	$62,600
2	$84,600
3	$106,600
4	$128,600
5	$150,600
6	$172,600
7	$194,600
8	$216,600

*Based on the 2025 Federal Poverty Level Guidelines

What if I do not meet the income limits?
If you cannot pay your bill, the Hospital can offer a payment plan. The amount you will pay depends on your income but in any event will not exceed 5% of your gross monthly income.

Can someone explain the discount? Can someone help me apply?
Yes, free, confidential help is available. Call the Patient Accounts Department at 1-718-518-2048. If you do not speak English, someone will help you in your own language. The Financial Counselor will explain and help you apply for a discount. The Counselor will help you fill out all the forms and tell you what documents you need to bring. Documents may include One month's Pay stubs /

Unemployment checks / Compensation papers / Social Security checks/copy of award letter(s) /W2 form for the previous year or other documentation to support the family annual income.

What do I need to apply for a discount?
The Admitting or Patient Accounts office will provide you with an application. Just complete the application and submit it to the Patient Accounts Department. An application and packet can be found on the hospital website at www.calvaryhospital.org/patients-families/patient-financial-information/ or by visiting the admitting or Patient Accounts department at the Hospital. You can also call 718-518-2048 for an application packet to be mailed to you.

What services are covered?
All provider services are covered under this policy except for Dr. Burger although contracted with Calvary Hospital bills for his own services and therefore his services are not included in Calvary's FAP policy.
Medically necessary services provided by physicians and other health care providers who treat you at Calvary Hospital whether employed by or directly contracted by the hospital are eligible. All listed provider services are covered under this policy except for Dr. Burger although contracted with Calvary Hospital bills for his own services and therefore his services are not included in Calvary's FAP policy.A complete listing of Calvary employed providers or contracted Providers can be found on the Calvary website www.calvaryhospital.org/patients-families/patient-financial-information/.

How much do I have to pay?
Discounts are determined based on the income test described above. You can pay as little as $0 if your income is 400% or less of the Federal Poverty Level and meet all the other qualifications for eligibility. Eligibility is based on annual family income and family size. See the below Federal Poverty Guidelines chart:

2025

Annual Guidelines

Family Size	100% Federal Poverty Guidelines	200% Federal Poverty Guidelines	250% Federal Poverty Guidelines	300% Federal Poverty Guidelines	350% Federal Poverty Guidelines	400% Federal Poverty Guidelines
1	$15,650	$31,300	$39,125	$46,950	$54,775	$62,600
2	$21,150	$42,300	$52,875	$63,450	$74,025	$84,600
3	$26,650	$53,300	$66,625	$79,950	$93,275	$106,600
4	$32,150	$64,300	$80,375	$96,450	$112,525	$128,600
5	$37,650	$75,300	$94,125	$112,950	$131,775	$150,600
6	$43,150	$86,300	$107,875	$129,450	$151,025	$172,600
7	$48,650	$97,300	$121,625	$145,950	$170,275	$194,600
8	$54,150	$108,300	$135,375	$162,450	$189,525	$216,600
More than 8 members add per member	$5,500	$11,000	$13,750	$16,500	$38,500	$55,000
DISCOUNT		**100%**	**90%**	**85%**	**80%**	**75%**

Calvary Hospital uses the Prospective Method to calculate Amounts Generally Billed (AGB). Qualified Patient Account Balances are adjusted to AGB first and then the financial aid discount is applied if applicable.
A Financial Aid (FAP) qualified individual will not be billed more than AGB.

If you are eligible for a discount the following rates would apply:

		200% FPL	250% FPL	300% FPL	350% FPL	400% FPL
		100%	90%	85%	80%	75%
Inpatient (per day)	$1,328.00	$0.00	$132.80	$199.20	$265.60	$332.00
Clinic	$128.87	$0.00	$ 12.89	$ 19.33	$ 25.77	$ 32.22
Physician						
99221	$90.15	$0.00	$ 9.02	$ 13.52	$ 18.03	$ 22.54
99222	$141.33	$0.00	$ 14.13	$ 21.20	$ 28.27	$ 35.33
99223	$188.00	$0.00	$ 18.80	$ 28.20	$ 37.60	$ 47.00
99231	$53.07	$0.00	$ 5.31	$ 7.96	$ 10.61	$ 13.27
99232	$85.88	$0.00	$ 8.59	$ 12.88	$ 17.18	$ 21.47
99233	$127.61	$0.00	$ 12.76	$ 19.14	$ 25.52	$ 31.90
99234	$105.38	$0.00	$ 10.54	$ 15.81	$ 21.08	$ 26.35
99235	$171.24	$0.00	$ 17.12	$ 25.69	$ 34.25	$ 42.81
99236	$223.89	$0.00	$ 22.39	$ 33.58	$ 44.78	$ 55.97
99238	$88.27	$0.00	$ 8.83	$ 13.24	$ 17.65	$ 22.07
Hospice						
BX/NY/QNS/WES/ROC/KINGS County						
Routine Day 1-60	$295.11	$0.00	$ 29.51	$ 44.27	$ 59.02	$ 73.78
Routine Day 61+	$232.44	$0.00	$ 23.24	$ 34.87	$ 46.49	$ 58.11
SIA (SN/MS visits during the last 7 days of life) per hour	$88.60	$0.00	$ 8.86	$ 13.29	$ 17.72	$ 22.15
Continuous Care (every 24 hours)	$2,126.50	$0.00	$212.65	$318.98	$425.30	$531.63
Respite	$681.57	$0.00	$ 68.16	$102.24	$136.31	$170.39
General Hospice Inpatient	$1,537.20	$0.00	$153.72	$230.58	$307.44	$384.30
Nassau County						
Routine Day 1-60	$284.62	$0.00	$ 28.46	$ 42.69	$ 56.92	$ 71.16
Routine Day 61+	$224.18	$0.00	$ 22.42	$ 33.63	$ 44.84	$ 56.05
SIA (SN/MS visits during the last 7 days of life) per hour	$85.46	$0.00	$ 8.55	$ 12.82	$ 17.09	$ 21.37
Continuous Care (every 24 hours)	$2,050.92	$0.00	$205.09	$307.64	$410.18	$512.73
Respite	$657.35	$0.00	$ 65.74	$ 98.60	$131.47	$164.34
General Hospice Inpatient	$1,482.56	$0.00	$148.26	$222.38	$296.51	$370.64
Home Care						
Skilled Nursing	$153.84	$0.00	$ 15.38	$ 23.08	$ 30.77	$ 38.46
Physical Therapy	$168.51	$0.00	$ 16.85	$ 25.28	$ 33.70	$ 42.13
Occupational Therapy	$169.31	$0.00	$ 16.93	$ 25.40	$ 33.86	$ 42.33
Speech Therapy	$182.77	$0.00	$ 18.28	$ 27.42	$ 36.55	$ 45.69
Social Worker	$246.58	$0.00	$ 24.66	$ 36.99	$ 49.32	$ 61.65
Home Aid per visit	$69.66	$0.00	$ 6.97	$ 10.45	$ 13.93	$ 17.42

How do I get the discount?
You have to fill out the application form. As soon as we have the information on your residency, income, and family size we can process your application for a discount.
You can apply for a discount before you have an appointment, when you come to the hospital to get care, or when the bill comes in the mail. Send the completed form to Calvary Hospital, 1740 Eastchester Road, Bronx, NY 10461.
Patients will have at least two hundred and forty (240) days from the date of service or discharge to apply for financial assistance. Patients will have at least another twenty (20) days from receipt of the application materials from the hospital to provide the information.

How will I know if I was approved for the discount?
The Hospital will send you a letter within 7 days after completion and submission of the application, telling you if you have been approved and the level of discount you qualify for. For unfavorable determinations the outstanding balances will be pursued via the hospital's "Billing and Collection Policy", which may include referrals to collection agencies. The collection agency will pursue an estate search and assets from the patient's estate. Collection agencies must obtain Hospital approval in writing before any legal action is initiated. A copy of the hospital Billing and Collection Policy is available by calling the Patient Accounts Department Director at 718-518-2064 or via Calvary Hospital web site: www.calvaryhospital.org/patients-families/patient-financial-information/.

What if I receive a bill while I'm waiting to hear if I can get a discount?
You are not required to pay a hospital bill while your application for a discount is being considered. If your application is turned down, the Hospital must tell you why in writing and must provide you a means to appeal the decision to a higher level within the Hospital.

What if I have a problem I cannot resolve with the Hospital?
You may call the New York State Department of Health complaint hotline at 1-800-804-5447.

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Calvary Hospital Financial Assistance Application Enclosed

Enclosed is the Financial Assistance Application, please complete the enclosed application in its entirety and return the completed application within 30 days to:

Calvary Hospital
1740 Eastchester Road

Bronx, NY 10465

Attn: Patient Accounts, Financial Assistance

After all items are received, your request will be reviewed and you will be notified in writing of your determination within thirty (30) days.

IMPORTANT

- ***No documentation to show proof of income or paid medical expenses is required when submitting this application***

If you have any questions, please do not hesitate to reach us at 718-518-2048.

Sincerely,

Financial Counseling Services

NYS Uniform Hospital Financial Assistance Application

You may be eligible for hospital financial assistance to pay your bills if you are uninsured, if your insurance is exhausted, or if you have health insurance but have proof of paid medical expenses totaling more than 10% of your income. Completing this form will start your request for hospital financial assistance. This form is used by all hospitals in New York State.

This application must be printed in the primary[1] languages spoken by patients served by the hospital.

Patient Name (complete information that is applicable)

Patient Name (First, Middle, Last)		
Date of Birth (mm/dd/yyyy)		
Address	Apartment/Unit #	
City	State	Zip
Contact Phone #		
Parent/Guardian or Lawful Representative Name (if patient is a minor child or an incapacitated adult)		
Email Address (if any)		

Family Information:

Please list below all family members in your household. Your household includes yourself, your spouse or domestic partner, and any children or other dependents. For example, this would include everyone listed on the same tax return.

Gross income means your income **before** taxes are deducted.

Gross income can consist of work earnings (wages, salaries, tips, earnings from self-employment), unearned income (social security, disability, and unemployment benefits), contributions (funds from family or friends), and other sources of income (temporary assistance and supplemental security income).

Full Name	Relationship	Total Gross Income (Current)
	Self	

[1] "Primary languages" includes any language that is used to communicate in at least 5% of patient visits per year, or any language spoken by more than 1% of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems.

The hospital may request you submit documentation as proof of income; examples of documentation might include a pay stub, a letter from your employer if applicable, or Form 1040.

Health Insurance Status

Do you have any form of health insurance, including Medicaid, Medicare, or private insurance through your employer or purchased on your own? ☐ Yes ☐ No

If you answered "No," would you like assistance in applying for any of these programs?

☐ Yes ☐ No

Underinsured patients: people with insurance and high medical expenses. If you have insurance, please provide an estimate of the medical bills you paid in the past 12 months.

$

The hospital may request you submit documentation as proof of paid medical expenses.

Patient/Responsible Party: If not the patient, list the name of the person signing the form and their authority to sign on behalf of the patient (e.g., spouse, parent, legal representative).

I understand that the information I submit may be subject to verification from external sources. I certify that the information is true and complete to the best of my knowledge.

Print Name Relationship to Patient	Date
Signature	

Minimum Eligibility and Guidelines

Application Timeline, Patient Rights, and Confidentiality

- You can apply for financial assistance at any point during the collection process.
- You do not have to make any payment to this hospital until you receive a decision on your application for financial assistance. Hospitals may not forward accounts to collection while your application is pending.
- If you are denied financial assistance, you have the right to appeal. Information on how to do so will be included in the hospital's notice you receive. You may have the right to appeal the amount of your financial assistance. The hospital will include information about how to appeal in their decision letter.
- Hospitals cannot send unpaid bills to a collection agency for at least 180 days after your first bill.
- Hospitals are prohibited from taking legal action, including filing lawsuits, to recover unpaid medical bills for patients below 400% of the federal poverty level. Poverty guidelines can be found here: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
- Any information provided in this application will only be used by the hospital to determine your eligibility for financial assistance and will remain confidential to the extent permitted by law.
- A hospital cannot deny you medically necessary services because you have an outstanding medical bill.
- If you need assistance with this application, please contact **Calvary Hospital, Inc**. financial assistance office at **718-518-2048.**
- If you need additional assistance with this application or help appealing a decision, you can reach out to Community Health Advocates: 888-614-5400.

Eligibility

Nothing limits a hospital's ability to establish patient eligibility for payment discounts at income levels higher than those specified below and/or to provide greater payment discounts for eligible patients than those required by Public Health Law. Additionally, immigration status shall not be an eligibility criterion for the purpose of determining financial assistance.

The following individuals are eligible:

- Low-income individuals without health insurance; or
- underinsured individuals (out-of-pocket medical costs accumulated in the past twelve months that amount to more than ten percent of such individual's gross annual income); or
- those who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges; or
- at the hospital's discretion, individuals who can demonstrate an inability to pay their co-pay and/or deductible can request a reduced or discounted payment.

Individuals up to 400% of the federal poverty level are eligible for financial assistance.

Federal Poverty Levels (2025)			
Household Size	**200%**	**300%**	**400%**
1 Person	$31,300	$46,950	$62,600
2 Persons	$42,300	$63,450	$84,600
3 Persons	$53,300	$79,950	$106,600
4 Persons	$64,300	$96,450	$128,600
5 Persons	$75,300	$112,950	$150,600
6 Persons	$86,300	$129,450	$172,600
7 Persons	$97,300	$145,950	$194,600

Updated annually: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Minimum Discount Rates

If you qualify for financial assistance, your charges will be reduced according to your income on a sliding fee scale as follows:

Income Level	**Payment**
Below 200% FPL	Waive all charges
200% - 300% FPL	Uninsured patients: Sliding scale up to 10% of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 10% of the amount that would have been paid pursuant to such patient's insurance cost sharing.
301% - 400% FPL	Uninsured patients: Sliding scale up to 20% of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 20% of the amount that would have been paid pursuant to such patient's insurance cost sharing.

Hospitals may choose to provide greater discounts for eligible patients and/or offer payment discounts for patients at higher income levels.

Installment Plans

Installment plans are available to patients who are unable to pay the reduced rate all at one time. Monthly payments cannot exceed 5% of your gross monthly income and the rate of interest charged to the patient on the unpaid balance, if any, shall not exceed 2%.

Request for Proof of Household Income

Please include the income information for the patient, their spouse, and any dependents (such as children). For example, this would include everyone on the same tax return (tax filer, spouse, and tax dependents) in the calculation of household income.

The following is a list of documents you can use to prove your income. You do not have to provide all these documents. You can also provide a statement of no household income if you have no income.

You may also provide the Eligibility determination page from the NY State of Health Marketplace. If you have this document, you do not have to provide any other income information listed below to the hospital.

If Household Receives:	**Amount per Month:**	**Applicant May Provide:**
Wages	$	Please provide one Paycheck Stub, or Letter from Employer on company letterhead, signed and dated, or most recently filed income tax return.
Social Security Payment	$	Copy of award letter/certificate, or correspondence from the U.S. Social Security Administration, or annual benefit letter. To request a copy of your Social Security benefit letter, call 1-800-772-1213 or visit www.ssa.gov.
Unemployment Compensation	$	Copy of award letter/certificate, or monthly benefit statement from NYS Department of Labor, or Copy of Direct Payment Card with printout, or Correspondence from the NYS Department of Labor, or Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us).
Disability Payment	$	Copy of award letter/certificate, or correspondence from Social Security Administration, or copy of annual benefit letter. To request a copy of your benefit letter, call 1-800-772-1213 or visit www.ssa.gov.
Workers Compensation	$	Copy of Award Letter or Check stub.
Alimony/Child Support	$	Copy of court order, or 3 months of cashed checks/receipts.
Dividends/Interest	$	Quarterly dividend statements or 1 month statements.
Other	$	Letter stating the amount of non-wage earnings (if any), such as rental income, cash for odd jobs, etc.
No Income	$0	Signed statement of no income.