**The Behavior Wellness Center at Girard**
Philadelphia, Pa. 19122

## Notice of Availability of Uncompensated Services

North Philadelphia Health System is required by law to give a reasonable amount of its service without charge to eligible persons who cannot afford to pay for health care.

The Department of Health and Human Services published in the Federal Register the latest poverty guidelines. To be eligible to receive subsidized care, your family income must be at or below the following levels:

| Size of family | Category A<br>100% of Poverty | Category B<br>200 % of Poverty |
|---|---|---|
| 1 | $12,880 | $25,760 |
| 2 | $17,420 | $34,840 |
| 3 | $21,960 | $43,920 |
| 4 | $26,500 | $53,000 |
| 5 | $31,040 | $62,080 |
| 6 | $35,580 | $71,160 |
| 7 | $40,120 | $80,240 |
| 8 | $44,660 | $89,320 |
| 8+ | Add $4,540 for each additional Family Member | Add $9,080 each additional Family Member |

Annual Income Limit Effective: 01/01/2022

If you think you may be eligible for uncompensated services, please contact a Financial Counselor at (215) 787-2350 or 787-2362 and you will be required to bring **Proof of Income** such as pay stub or Federal Income Tax return, with your written request.

North Philadelphia Health System will decide your eligibility for uncompensated services within two (2) working days of your request.

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## Application for Free, or below Charges

Application is made based on the information given below for free or below charge. I understand that this information must be true and accurate to the best of my knowledge and that the facility may take any reasonable action to verify. If the information proves to be untrue, the facility may review my case and take whatever action becomes suitable.

☒ _____ _____
Signature of Patient, Guarantor or Representative Date

The patient is required to formulate application for any help (Medicaid, Medicare or Insurance) which may be available for payment to the hospital.

Income of Family:

| | Number in same Household | Income for the Last 3 months | Income for the last 12 months |
|---|---|---|---|
| Single Person | _____ | _____ | _____ |
| Husband | _____ | _____ | _____ |
| Wife | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| Other Dependents | _____ | _____ | _____ |
| Total Family Size | _____ | _____ | _____ |

Services provided on (date) _____ (discharged) _____

**Business Office Use Only**

☐ **Approval:**

On _____, I determined that the above patient is eligible for free care, and have advised the patient.
Date

☐ **Denial:**

On _____, I determined that the above patient was not eligible for free care, and have advised the patient what the reason for denial is

_____

☒ _____ _____
Signature of Financial Counselor/Manager/Director Date

(Income includes wages before deductions, receipts from self-employment, public assistance payments, social security, unemployment and workers' compensation, strike benefits, veterans' benefits, training stipends, alimony, child support and military family allotments or other regular support from an absent family member, regular insurance or annuity payments, dividends, rent, interest, royalties, or income from estate and trusts.)