L|E|C|O|M
MEDICAL CENTER

5515 Peach St.
Erie, PA 16509
Phone: (814) 864-4031

LECOM MEDICAL CENTER FINANCIAL ASSISTANCE

Criteria and rates charged for Financial Assistance:

LECOM Medical Center will provide, without exception, care for **emergency medical conditions** to all patients seeking such care, regardless of ability to pay or to qualify for financial assistance, in accordance with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA).

Eligible services are for emergency and medically necessary services only. Financial Assistance does not apply to cosmetic services.

Financial Assistance is available for:

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured: A patient that has out-of-pocket expenses that exceed his/her financial abilities.

Rates and Basis for Financial Assistance:

If you qualify for financial assistance, discounts in the form of Charity Care are applied. **(Click here to see the Financial Assistance Income Scale in the Hospital Charity Care policy at the Hospital website).**

If you are Self-pay (uninsured), or your coverage (all or part) does not cover certain procedures, you will be charged at Medicare rates.

Following a determination of Financial Assistance Policy (FAP) eligibility, an FAP-eligible will not be charged more than the Amounts Generally Billed (AGB) for emergency or other medically necessary care. The Hospital uses the Prospective method for determining AGB.

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How to Apply for Financial Assistance

We automatically initiate Financial Assistance procedures in the form of self-pay adjustment to the Medicare rates if you are self-pay.

If you are unable to pay you can obtain a Charity Care Application. For assistance in completing the application, please contact our Financial Counselor at 814-868-7719.

Mail the completed application to:

LECOM Medical Center
Attn: Financial Counselor
5515 Peach Street
Erie, PA 16509

Or Fax to: 814-868-7770

Actions Taken in the Event of Nonpayment

In the event of nonpayment, your account may get referred to a third party collection agency. MCH will make reasonable efforts to notify you of its Financial Assistance Policy including a period no less than 120 days from the first billing statement.

Where is the Financial Assistance Policy Available

Paper copies of the Financial Assistance Policy Summary (FAP), Financial Assistance Application, and Charity Care policy are available at the registration desk, front desk, and the LECOM Medical Center website (**http://lecomhealth.com/community-hospital/patient-services*)*.**

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LECOM Medical Center is a not-for-profit teaching hospital that is committed to provide excellent medically necessary healthcare services regardless of our patient's ability to pay. The hospital realizes that some of our patients are unable to pay for medically necessary healthcare services and those individuals will be provided charity care as established by the hospital's charity care policy available on the web and in writing by request.

APPLICATION FOR CHARITY CARE

Section One: Required Questions
Please complete all questions in this section. Failure to complete this section could result in delays in evaluating your eligibility for charity care.

Patient Information

Patient Name _____ Date of Birth _____

Street Address _____

City/State/Zip _____

Telephone: Home _____ Cell _____ Work _____

Household Members (in addition to yourself)

Name	Relationship	Age
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Household Income (all wages for every person):

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Current proof of income from the last 30 days is required for all sources of income listed below. Proof of Income consists of Pay Stubs, Prior Year Tax Return, Letter of Benefit for Social Security and/or Disability etc. must be attached to this application in order to process.

Wages (before taxes) _____ Pension _____

Social Security _____ Other Disability _____

Cash Assistance _____ Supplemental Security Income (SSI) _____

Unemployment Compensation _____ Workers Compensation _____

Child & Spousal Support _____ Other Income _____

Section Two: Optional Questions

If you so choose, please answer the questions below to provide a better understanding of your ability to pay for medical care. Higher than average or otherwise unusual expenses could adjust your income downward. Lower expenses will NOT adjust your income upward.

Monthly Expenses:

Mortgage / Rent _____ Insurance _____

Credit Cards _____ Gas/Electric _____

Child/Spousal Support _____ Other (please explain)

_____

Certification

*Please sign and return required documents** with this completed application.*

I certify that the information contained in this application is true and complete. I understand that willful falsification of information contained in this application will result in denial of charity care.

Signed: _____ Dated: _____

**In order for your application to be processed, you must provide documentation of income for all Household Members. If you have any questions on this form, please contact Patient Accounting at 814-868-7719.