York Hospital
Caring for All

THE PROGRAM:

The Help at Every Level Program (HELP) offers reductions on patient hospital bills based on visits related to one encounter/reason, household income and the amount owed.

QUALIFICATIONS/REQUIREMENTS:

Bills must have patient balance $1,000 or over, related to same encounter/reason

Application and required documentation showing last 12 months of income.

Payment must be made in full (can be up to three installments within 90 days) from approval.

ELIGIBILTY: Please see below chart.

Percent of amounts owed to York Hospital

Household Income Level	Balance $1,000-$5,000	Balance $5,001-$7,500	Balance $7,501-$10,000	Balance $10,001-$15,000	Balance $15,001-$20,000	Balance $20,001-$50,000	Balance >$50,001
$25,000-$30,000	60%	50%	40%	30%	20%	10%	10%
$30,001-$40,000	70%	60%	50%	40%	30%	20%	15%
$40,001-$50,000	80%	70%	60%	50%	40%	30%	20%
$50,001-$75,000	90%	80%	70%	60%	50%	40%	30%
$75,001-$100,000	100%	85%	80%	70%	60%	50%	40%
$100,001-$150,000	100%	85%	80%	75%	70%	60%	50%
$150,001-$200,000	100%	90%	85%	80%	75%	70%	50%
>200,000	100%	90%	85%	80%	80%	70%	50%

REQUIRED DOCUMENTATION:

Proof of household income for last 12 months. This would be income from 2023, as well as 2024 year to date. See below for acceptable documents.

ACCEPTABLE DOCUMENTS:

Copy of 2023 tax return. As well as proof of income from 2024.

If you do not have a 2023 tax return, we can accept items from the below list.

W-2's
Pension
Social Security Retirement or Disability Benefit
Unemployment Compensation
Disability Compensation - begin/end dates.
Workers Compensation Benefit - begin/end dates
Profit/Loss - if not shown on 2023 Federal Tax Return
Child Support/Alimony - if not shown on 2023 Federal Tax Return

2024 HELP Application

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Patient Information:

_____

Last Name First Name Middle Initial Social Security Number Date of Birth

_____

Mailing street address City State Zip Code

_____

Email Contact phone number

If person submitting application is different from patient:

_____

Last Name First Name Middle Initial Social Security Number Date of Birth

_____

Email Contact phone number

Please list below patient accounts to be considered for this application:

Visit ID number: _____ Date of Service _____ Amount Due _____

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Visit ID number: _____ Date of Service _____ Amount Due _____

I understand the information which I submit regarding my household annual income is subject to verification by York Hospital. I understand that if the information submitted is determined to be false, such determination will result in the denial of HELP by York Hospital, and I will be liable for the balances due.

I affirm the above to be true and correct.

_____

Applicant (please print). If not, relationship to patient

_____ _____

Signature Date