

2023 HELP Application
(Help at Every Level Program)



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

ELIGIBILITY: 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 2022, as well as 2023 year to date. See below for acceptable documents.

ACCEPTABLE DOCUMENTS:

Copy of 2022 tax return. As well as proof of income from 2023.

If you do not have a 2022 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 2022 Federal Tax Return
Child Support/Alimony - if not shown on 2022 Federal Tax Return

2023 HELP Application



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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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