Financial Assistance Policy – Plain Language Summary

Community Memorial Hospital provides emergency care and medically necessary health services without regard to a patient’s ability to pay. Financial Assistance is available for eligible patients to help defray the cost of these services.

**Eligible Services:** Emergency Care means those services that are delivered in the Emergency Department. Medically Necessary Services are those services that are necessary to prevent, diagnose, or treat conditions that cause acute suffering, endanger life, or result in illness or infirmity. Financial Assistance is **not available** for Swing Bed Services. The primary service areas covered by our Financial Assistance Program are the counties of Chenango, Cortland, Madison, Oneida, Onondaga, Oswego and Otsego, in addition to all residents of New York State. Financial Assistance is also available to eligible patients to decrease the cost of deductibles, coinsurance, and co-payments, with the exception of services provided in the hospital based physician primary care offices.

**Eligible Patients:** Patients receiving eligible services, who submit a completed Financial Assistance Application, and who are determined eligible by the Community Memorial Hospital Financial Counseling Office.

**How to Apply:** Applications for Financial Assistance may be obtained as follows:

- Obtain an application in person at Community Memorial Hospital Registration or Financial Counseling Office, online at [http://www.communitymemorial.org/financial-assistance/](http://www.communitymemorial.org/financial-assistance/), request by mail by calling 315 824 6553 or send request in writing to Community Memorial Hospital, 150 Broad Street, Hamilton NY 13346.
- Return completed applications with required proof of income to Community Memorial Hospital, Attention: Financial Counseling Department, 150 Broad Street, Hamilton, NY 13346.

Determination of Financial Assistance Eligibility – Generally, patients are eligible for financial assistance based on their household income levels, as compared to the federal poverty guidelines. Assistance ranges from 100% write-off of charges to the Hospital’s “**Amounts Generally Billed**” or “AGB.” AGB means the amounts generally billed to insured individuals and is calculated based on all claims allowed by Medicare and private health insurers over a 12 month period, divided by the associated gross charges for those claims. See attached for Financial Assistance Summary and Application materials.
Discount Levels (based on FPL chart below):
% discount of AGB
100% 75% 50% 25% AGB*
% discount on deductibles, copay, or coinsurance balances only
100% 25%
Persons in Family Unit 100 - 150% FPL 151 - 175% FPL 176 - 200% FPL 201 - 250% FPL 251 - 300% FPL
1 12,490 - 18,735 18,736 - 21,858 21,859 - 24,980 24,981 - 31,225 31,226 - 37,470
2 16,910 - 25,365 25,366 - 29,593 29,594 - 33,820 33,821 - 42,275 42,276 - 50,730
4 25,750 - 38,625 38,626 - 45,063 45,064 - 51,500 51,501 - 64,375 64,376 - 77,250
5 30,170 - 45,255 45,256 - 52,798 52,799 - 60,340 60,341 - 75,425 75,426 - 90,510
6 34,590 - 51,885 51,886 - 60,533 60,534 - 69,180 69,181 - 86,475 86,476 - 103,770
7 39,010 - 58,515 58,516 - 68,268 68,269 - 78,020 78,021 - 97,525 97,526 - 117,030
Add for each additional person 4,420 - 6,630 6,631 - 7,735 7,736 - 8,840 8,841 - 11,050 11,051 - 13,260

Any resident of Chenango, Madison, Oneida, Onondaga, Oswego, and Otsego counties, and all residents of New York State that receive services at Community Memorial Hospital are eligible to apply for this program. Please complete and return the attached application with requested documentation to the address above.

Questions regarding this policy may be directed to the Community Memorial Hospital Financial Counseling Office at 315-824-6552 or 315-824-6553.
REQUESTS FOR DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE

PLEASE RETURN THIS FORM AND DOCUMENTATION REQUESTED TO THE ABOVE ADDRESS WITHIN 30 DAYS. YOU WILL RECEIVE NOTIFICATION WITHIN 30 DAYS FROM THE RECEIPT OF YOUR APPLICATION STATING WHETHER YOU HAVE BEEN APPROVED AND THE LEVEL OF DISCOUNT RECEIVED. IF YOUR APPLICATION IS DENIED YOU MAY FILE AN APPEAL BY CONTACTING THE CHIEF FINANCIAL OFFICER AT 315-824-6081. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE IN COMPLETING THIS APPLICATION, PLEASE CONTACT FINANCIAL COUNSELING AT 315-824-6552 or 315-824-6553.

DATE OF REQUEST: ______________________

PATIENT’S NAME ______________________

RESPONSIBLE PARTY (IF PATIENT IS A MINOR): ______________________

ADDRESS: ______________________

PHONE NUMBER: ______________________ DATE OF BIRTH: ______________________

EMPLOYER: ______________________ OCCUPATION: ______________________

INCOME PROOF: __________ Proof of income from unemployment, social security, pensions, worker’s compensation, disability, etc.

For self-employed persons, a 3 month business ledger or self-attestation form (a tax return is optional)

<table>
<thead>
<tr>
<th>LIST HOUSEHOLD INCOME</th>
<th>TOTAL FOR LAST MONTH</th>
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<tbody>
<tr>
<td></td>
<td>PATIENT</td>
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<tr>
<td>Wages</td>
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<tr>
<td>Farm/self employed</td>
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<td>Social security</td>
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<td>Unemployment</td>
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<td>Alimony/child support</td>
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<td>Disability</td>
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<td>Workers’ compensation</td>
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<tr>
<td>Dividends/interest/rentals</td>
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<td>Military allotment</td>
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<tr>
<td>Pension</td>
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<td>All other income</td>
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</tbody>
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Household size—Please be sure to list all household members and include any dependent children with ages

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<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
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I AFFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE: _______________ SIGNATURE: ______________________

NO PAYMENT IS REQUIRED DURING THE REVIEW PROCESS UNTIL YOU RECEIVE A DETERMINATION FROM THIS OFFICE.
Self-Attestation of Income

This form should be used by patients and members of their households who are self-employed or have no other type of documentation to verify their income.

Name: _____________________________________________ Phone: __________________

Address: ____________________________________________________________________

City: ____________________________ State: _________ Zip Code: _______________

☐ I get paid in cash and do not receive a pay stub
☐ I am self-employed
☐ I am unemployed and have no income

Please indicate your gross monthly income: $______________________________________

I certify that I have no other way to document the above income. I affirm that the income information provided is true, complete, and correct to the best of my ability.

Signature: ____________________________ Date: __________________