Community Memorial

150 Broad Street
Hamilton, NY 13346

Quality Care, Close to Home

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/, 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.

Community Memorial Hospital
150 Broad Street
Hamilton, NY 13346

2020 Financial Assistance Program Summary

Emergency and medically necessary services covered by this program are:

1. Admitted acute care patients
2. Emergency services patients
3. Ambulatory Surgery patients
4. Referred ambulatory patients
5. Observation patients
6. Hospital based physician office patients **(uninsured patients only)**

Note: This program is not available for Swing Bed Services

Financial Assistance is also available to eligible patients to decrease the cost of coinsurance, co-payments and deductibles, **except at the hospital based physician offices.**

The amount of reduction in charges will be based on the most current Health & Human Services Guidelines. The following chart is based on the number of persons in the household and individual or household income of 100% to 375% of the Federal Poverty Level (FPL).

Discount Levels (based on FPL chart below):

Uninsured (No Insurance):

% discount of AGB	100%	75%	50%	25%	AGB*

Underinsured (After Insurance): ***Hospital accounts only**

% discount on deductibles, copay, or coinsurance balances only	100%	50%	25%

Persons in Family Unit	100 - 150% FPL	151 - 175% FPL	176 - 200% FPL	201 - 250% FPL	251 - 375% FPL
1	12,760 - 19,140	19,141 - 22,330	22,331 - 25,520	25,521 - 31,900	31,901 - 47,850
2	17,240 - 25,860	25,861 - 30,170	30,171 - 34,480	34,481 - 43,100	43,101 - 64,650
3	21,720 - 32,580	32,581 - 38,010	38,011 - 43,440	43,441 - 54,300	54,301 - 81,450
4	26,200 - 39,300	39,301 - 45,850	45,851 - 52,400	52,401 - 65,500	65,501 - 98,250
5	30,680 - 46,020	46,021 - 53,690	53,691 - 61,360	61,361 - 76,700	76,701 - 115,050
6	35,160 - 52,740	52,741 - 61,530	61,531 - 70,320	70,321 - 87,900	87,901 - 131,850
7	39,640 - 59,460	59,461 - 69,370	69,371 - 79,280	79,281 - 99,100	99,101 - 148,650
8	44,120 - 66,180	66,181 - 77,210	77,211 - 88,240	88,241 - 110,300	110,301 - 165,450
Add for each additional person	4,480 - 6,720	6,721 - 7,840	7,841 - 8,960	8,961 - 11,200	11,201 - 16,800

* "**Amounts Generally Billed**" or "**AGB**" means the amounts generally billed to insured individuals. The AGB percentage is calculated by Community Memorial Hospital 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.

Specific documentation requested for **each member of the household**:

1. Last 4 consecutive weeks of pay stubs (2 if paid bi-weekly).
2. Proof of income from unemployment, Social Security, pension, Worker's Compensation, disability, etc.
3. For self-employed persons or persons without income, complete attached Self-Attestation form or submit a 3 month business ledger.

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.

COMMUNITY MEMORIAL HOSPITAL
FINANCIAL COUNSELING DEPARTMENT
150 BROAD STREET
HAMILTON, NY 13346

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 _____
LAST FIRST MIDDLE

RESPONSIBLE PARTY (IF PATIENT IS A MINOR): _____

ADDRESS: _____

PHONE NUMBER: _____ DATE OF BIRTH: _____

EMPLOYER: _____ OCCUPATION: _____

INCOME PROOF:
_____ LAST 4 CONSECUTIVE WEEKS OF PAY STUBS, 2 IF PAID BI-WEEKLY
_____ 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)

LIST HOUSEHOLD INCOME	**TOTAL FOR LAST MONTH**			
	PATIENT	**SPOUSE OR PARTNER**	**PARENT** (IF PATIENT IS A CHILD)	**TOTAL**
WAGES				
FARM/SELF EMPLOYED				
SOCIAL SECURITY				
UNEMPLOYMENT				
ALIMONY/CHILD SUPPORT				
DISABILITY				
WORKERS' COMPENSATION				
DIVIDENDS/INTEREST/RENTALS				
MILITARY ALLOTMENT				
PENSION				
ALL OTHER INCOME				

HOUSEHOLD SIZE—PLEASE BE SURE LIST **ALL HOUSEHOLD MEMBERS** AND INCLUDE **ANY DEPENDENT CHILDREN WITH AGES**

NAME	RELATIONSHIP	NAME	RELATIONSHIP
_____		_____	
_____		_____	
_____		_____	

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.

Community Memorial

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 am 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: _____