

Application for Patient Financial Assistance Program

(Please print)

Name: _____

Address: _____

City: _____

State: _____ Zip: _____ Phone: _____

Family Size/Household: _____

	INCOME #1	INCOME #2
1) WAGES	_____	_____
2) SOCIAL SECURITY	_____	_____
3) UNEMPLOYMENT COMPENSATION	_____	_____
4) DISABILITY	_____	_____
5) WORKERS' COMPENSATION	_____	_____
6) ALIMONY/ CHILD SUPPORT	_____	_____
7) DIVIDENDS, INTEREST, RENT	_____	_____
9) ALL OTHER INCOME	_____	_____

**PLEASE ENCLOSE A COPY OF YOUR MOST RECENT
PAY STUB ALONG WITH YOUR CURRENT TAX
RETURN WITH ALL SCHEDULES.**

IN ORDER TO QUALIFY FOR THE PATIENT ASSISTANCE PROGRAM, YOU MUST MEET ONE OF THE CIRCUMSTANCES LISTED UNDER "INABILITY TO PAY" IN THIS BROCHURE. PLEASE SELECT THE LETTER(S) OF THE CHOICES THAT BEST MEETS YOUR NEEDS AND EXPLAIN WHAT YOUR REQUEST IS OF THIS PROGRAM.

I AFFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE: _____

SIGNATURE: _____

Tear here, attach all relevant documents and put them in the supplied self-addressed, postage-paid envelope.

Glens Falls Hospital Patient Assistance Program — 2006 Income Guidelines

Eligibility is determined by comparing gross family income with the following income poverty guidelines:

Family Size	Poverty Guidelines		100%		137.5%		175%		212.5%		250%	
	Discount		100%		80%		60%		40%		20%	
1			0 - \$9,800		\$9,801 - \$13,476		\$13,477 - \$17,150		\$17,151 - \$20,825		\$20,826 - \$24,500	
2			0 - \$13,200		\$13,201 - \$18,151		\$18,152 - \$23,100		\$23,101 - \$28,050		\$28,051 - \$33,000	
3			0 - \$16,600		\$16,601 - \$22,826		\$22,827 - \$29,050		\$29,051 - \$35,275		\$35,276 - \$41,500	
4			0 - \$20,000		\$20,001 - \$27,501		\$27,502 - \$35,000		\$35,001 - \$42,500		\$42,501 - \$50,000	
5			0 - \$23,400		\$23,401 - \$32,176		\$32,177 - \$40,950		\$40,951 - \$49,725		\$49,726 - \$58,500	
6			0 - \$26,800		\$26,801 - \$36,851		\$36,852 - \$46,900		\$46,901 - \$56,950		\$56,951 - \$67,000	
7			0 - \$30,200		\$30,201 - \$41,526		\$41,527 - \$52,850		\$52,851 - \$64,175		\$64,176 - \$75,500	
8			0 - \$33,600		\$33,601 - \$46,201		\$46,202 - \$58,800		\$58,801 - \$71,400		\$71,401 - \$84,000	

Add \$3,400.00 for each additional family member.

PATIENT FINANCIAL ASSISTANCE PROGRAM

Glens Falls Hospital



For more info on the Glens Falls Hospital
Patient Financial Assistance Program,
call 926-5111.



Glens Falls Hospital recognizes that there are times when patients in need of care will be unable to pay for the needed health care services provided. The intent of the Patient Financial Assistance Program is to alleviate the burden of payment to patients who are truly unable to pay.

GENERAL INFORMATION

Glens Falls Hospital will make Patient Financial Assistance available to patients who are unable to pay for the services rendered. The Hospital Board of Governors, on an annual basis, will approve the amount of Patient Financial Assistance to be provided by the Hospital. All available funds will be used on a first-come, first-served basis for eligible patients.

ELIGIBILITY

A patient's eligibility for Patient Financial Assistance will be based upon the size of the applicant's family and is limited to those families whose income is less than or equal to **2 ½ times (250%)** of the current poverty level income guidelines as determined by the Community Services Administration. In addition, applicants must demonstrate that they are unable to pay for the services rendered. A reduced level of assistance is also available for applicants whose income is greater than the poverty line income up to 2 1/2 times (250%) of the poverty line.

INABILITY TO PAY

Inability to pay is defined as a patient's lack of available financial resources to pay for hospital



services rendered. Potential reasons for this must be demonstrated in writing and may include the following:

- a) Patients or guarantors who are disabled.
- b) Patients or guarantors who are unemployed and who do not anticipate being employed in the near future.
- c) Patients or guarantors who are only seasonally employed and whose financial resources are minimal.
- d) Patients who are incarcerated subsequent to hospital services rendered.
- e) Patients who are enduring a temporary catastrophic period in their lives. (Ex: car accident, major illness)
- f) Inpatients who are not eligible for Medicaid.

COVERED SERVICES

Patient Financial Assistance funds will be utilized for all services rendered at Glens Falls Hospital with the exception of cosmetic procedures. Those patients who are applying for coverage of inpatient services must first have applied for and then been denied Medicaid eligibility.

APPLICATION PROCESS

Patients seeking access to the Patient Financial Assistance Program will complete an application under the guidance of a Patient Financial Services representative. During an interview, the determination of eligibility and inability to pay will be made contingent upon the patient producing income verification and a Medicaid denial, if necessary. Patient Finance will render a decision within (5) five working days of receipt of all



necessary patient documentation. Any application will be considered withdrawn if all requested documentation is not presented within 15 working days of the request.

MISCELLANEOUS

Separate applications for Patient Financial Assistance must be made for EACH occasion of hospital services. If the documentation used to prove eligibility is found to be fraudulent, then any Patient Financial Assistance awarded will be revoked and all normal collection efforts will be pursued.

Acceptable Income Verification:

1. Current pay stub
2. Most recent income tax return including all schedules (Federal Tax Return will be used to determine family size/gross income. Proof of Self-Employment gross income is required.
3. Any official documentation that clearly demonstrates one's current financial situation. (Ex: Pension checks, Social Security checks, etc.)

** (1) and (2) must be provided for review to award any Patient Financial Assistance funds

Patient Financial Assistance will only be applied after all insurance coverage has been exhausted. A Patient Financial Assistance application must be made within 90 days after receipt of the initial bill from Glens Falls Hospital. The Hospital reserves the right to terminate this program at any time without notice. Patients, or responsible parties, whose income falls within the Community Service Administration poverty guidelines may qualify for free medical care.