

# APPLICATION FOR PATIENT FINANCIAL ASSISTANCE

(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	_____	_____
8) ALL OTHER INCOME	_____	_____

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

## 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.*

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

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

### Glens Falls Hospital Patient Assistance Program - 2011 Income Guidelines

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

Family Size	% of Guideline	You Pay		131%-180%	181%-230%	231%-280%	281%-330%	331%+ 65% of Charges
		Federal Guidelines	Below					
1	\$10,890	\$0 - \$14,157	\$14,158 - \$19,602	\$19,603 - \$25,047	\$25,048 - \$30,492	\$30,493 - \$35,937	\$35,938	\$35,938
2	\$14,710	\$0 - \$19,123	\$19,124 - \$26,478	\$26,479 - \$33,833	\$33,834 - \$41,188	\$41,189 - \$48,543	\$48,544	\$48,544
3	\$18,530	\$0 - \$24,089	\$24,090 - \$33,354	\$33,355 - \$42,619	\$42,620 - \$51,884	\$51,885 - \$61,149	\$61,150	\$61,150
4	\$22,350	\$0 - \$29,055	\$29,056 - \$40,230	\$40,231 - \$51,405	\$51,406 - \$62,580	\$62,581 - \$73,755	\$73,756	\$73,756
5	\$26,170	\$0 - \$34,021	\$34,022 - \$47,106	\$47,107 - \$60,191	\$60,192 - \$73,276	\$73,277 - \$86,361	\$86,362	\$86,362
6	\$29,990	\$0 - \$38,987	\$38,988 - \$53,982	\$53,983 - \$68,977	\$68,978 - \$83,972	\$83,973 - \$98,967	\$98,968	\$98,968
7	\$33,810	\$0 - \$43,953	\$43,954 - \$60,858	\$60,859 - \$77,763	\$77,764 - \$94,668	\$94,669 - \$111,573	\$111,574	\$111,574
8*	\$37,630	\$0 - \$48,919	\$48,920 - \$67,734	\$67,735 - \$86,549	\$86,550 - \$105,364	\$105,365 - \$124,179	\$124,180	\$124,180

\*Add \$3,820 for each additional family member



## Glens Falls Hospital Patient Financial Assistance Program

**For more information on Glens Falls Hospital's Patient Financial Assistance Program, please call 926-5111.**

**Return completed application to Glens Falls Hospital, Attn: Christine LaFountain, 100 Park Street, Glens Falls, NY 12801**



## GENERAL INFORMATION

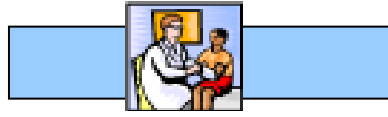
Glens Falls Hospital will make Patient Financial Assistance available to qualified patients. Glens Falls Hospital recognizes that there are times when patients in need of care will be unable to pay for the needed health care services provided. It is the policy of Glens Falls Hospital to provide and promote a consistent methodology for extending financial assistance to qualified patients in order to facilitate payment for hospital services.

## 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 **3.3 times (330%)** 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. Glens Falls Hospital will then use the attached guidelines to determine the appropriate level of financial assistance.

## DESCRIPTION OF SERVICE AREA

Glens Falls Hospital will extend financial assistance to all eligible patients including patients whose residency falls outside our primary service area within New York State as well as patients whose residency is outside New York State.



## INABILITY TO PAY

Eligible patients are requested to provide income verification every six months. Once qualified, the Hospital will use income information to determine levels of financial assistance for each six-month period. Patients must demonstrate that they are not eligible for Medicaid. The Hospital will provide assistance in obtaining Medicaid coverage, if required documents are provided to the Hospital in a timely manner.

## COVERED SERVICES

Patient Financial Assistance funds will be utilized for all services rendered by Glens Falls Hospital, including Adirondack Medical Services, with the exception of cosmetic procedures and hearing aids. Charges from private Physicians who provide services at the hospital are not covered. (example: Radiologist/Pathologists/Anesthesiologists)

## 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 this process, the determination of eligibility will be made contingent upon the patient producing income verification (tax returns) and a Medicaid denial, if applicable.



The Patient Financial Services Department will render a decision within ten (10) business days of receipt of all necessary patient documentation. Any application will be considered withdrawn if all requested documentation is not presented within twenty (20) days of the request. If the documentation used to prove eligibility is found to be fraudulent, any Patient Assistance awarded will be revoked and all normal collection efforts will be pursued.

## ACCEPTABLE INCOME VERIFICATION

1. Most recent income tax return (Federal Tax Return will be used to determine family size/adjusted gross income.)
2. Self-Employed individual's income calculation will be based on adjusted gross income reported on IRS tax form – 1040.
3. Other income documentation (example: SSI, SSD or pension statement)

Patient Financial Assistance will only be applied after all insurance coverage has been exhausted or for uninsured self-pay patients. A Patient Financial Assistance application must be made within 90 days after receipt of the initial bill from Glens Falls Hospital.