ArnotHealth

2020

APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM

Financial Assistance is available to individuals/families that are unable to pay the cost of Medically Necessary hospital services as defined by CMS and have gross income and resources that do not exceed the guidelines listed on this application. Applications may be submitted within 12 months of the date of service. The Financial Assistance Committee may also consider applications with unusual circumstances that might not normally be eligible.

TO BE ELIGIBLE, THE APPLICANT MUST PROVIDE THE FOLLOWING:

1. A fully completed, signed, and dated application.
2. Verification of income for all eligible family members. Four (4) weeks of paystubs are required, previous year tax returns, or other documented proof of monthly income sources.
3. A denial from Medicaid or other New York State program, in those cases where the Hospital believes the applicant may be eligible to receive help to pay their hospital bills.
4. Signed application on page 6.

Call our help line, 607.737.7777 (Hospitals) or 607.271.2050 (AMS) for information or questions. Certain elective procedures, (e.g., cosmetic surgery) are not eligible for financial assistance.

Applicant's Name:

_____

(Please Print) Last Name First Name MI

Social Security Number: ___ - __ - ____ Date of Birth: __ / __ / ____

Address: _____

City: _____ State: _____ Zip Code: _____

County of Residence: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Application: __ / __ / ____ Initial Date of Hospitalization: __ / __ / ____

Circle the Hospital where services were provided:

Arnot Ogden Medical Center St. Joseph's Hospital Ira Davenport Memorial Hospital

Arnot Health Physician Services

Marital Status: _____ Spouse Name: _____

EMPLOYMENT INFORMATION

❑ Applicant's Employer (or most recent employer)	Spouses Employer
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____

Number of Members in the Household: _____ (Includes self, spouse, minor children, and adults for whom the applicant is legally responsible; a pregnant woman counts as two family members).

Household Information: Include spouse, children or others that you support:
Check box if member is also applying for assistance.

	Name	Date of Birth	Relationship
❑	_____	_____	_____
❑	_____	_____	_____
❑	_____	_____	_____
❑	_____	_____	_____

ASSETS CRITERIA

Assets: _____

Assets Include:

A. Cash
   _____
B. Savings Accounts
   _____
C. Checking Accounts
   _____
D. Certificates of Deposit
   _____
E. Equity in Real Estate (other than primary resident)
   _____
F. Other Assets (bonds/stocks)
   _____

G. Total $: _____

INCOME CRITERIA

SOURCES OF INCOME

Income is based on the calculation of twelve months, or one month of income prior to the date of service. Proof of income must accompany this application.

	Amount	Weekly/Monthly/Yearly
Salary and Wages before Deductions		
Social Security Benefits		
Unemployment/Workmen's Compensation		
Alimony		
Other Monetary Support		
Pension Payments		
Insurance or Annuity Payments		
Dividends/Interest		
Rental Income		
Net Business Income (self employed/verified by copy of income tax)		
Other Income		
Total	$	

REQUIRED DOCUMENT CHECKLIST

We want to process your application as quickly as possible and need your help in providing all of the required documents listed below. If you are unable to obtain any of the documents, please include an explanation of why you cannot send it with your application. Incomplete applications will not be processed until all of the required documents and information are submitted.

- ❑ Copy of the Medicaid "Notice of Decision on your Medical Assistance Application" or determination letter from the NYS marketplace.

- ❑ Reason for excluding required information: _____

  _____

- ❑ Proof of residency (utility bill- not cell phone or cable/satellite)—Envelopes and any other bills are not acceptable forms of address verification. If no utilities are in your name, please supply a letter from the homeowner or your lease agreement verifying your address/living arrangement.

  Reason for excluding required information: _____

  _____

- ❑ Most recent banking, investment statements, or other documentation of assets (i.e. IRAs, or investments)—Monthly mailed statements, complete downloaded and printed online statement, or statements printed at the bank are the only acceptable format and must include all pages.

  Reason for excluding required information: _____

  _____

- ❑ Proof of current net income—Last four pay stubs, worker's compensation, unemployment, disability, alimony, Social Security Benefits (letter of determination, not direct deposit in bank acct)

  Reason for excluding required information: _____

  _____

- ❑ W-2 and tax return (optional)—If you are self employed you must include your Schedule C Profit and Loss form to satisfy proof of current net income.

  Reason for excluding required information: _____

  _____

A determination of eligibility will be made within 30 days of our receipt of the application and proof of income. Applications submitted without proof of income or a letter of explanation will be automatically returned for additional information. Applications are not open-ended. Your determination letter will give start and end dates.

Completed applications should be forwarded to:

Hospitals and Physician Services
Arnot Health Billing Department
Financial Assistance
555 St. Joseph's Blvd
Elmira, NY 14901

I understand that the information I submit is subject to verification by Arnot Health, Inc. I certify that the above information is true and correct to the best of my knowledge. Verification will be done by means including the following; credit bureau inquiries and employment verification.

Name (please print): _____

Signature: _____ Date: _____

DATE OF ISSUE: 03/13

DATE(s) OF REVISION: 8/13, 6/14, 2/16, 6/16, 2/17,12/17,1/22/19,2/2020

Community Care Plan

Arnot Ogden Medical Center, Ira Davenport Memorial Hospital and St. Joseph's Hospital

Income Eligibility Chart

2020

INDIGENT CARE

Family Size	GROSS INCOME & FAMILY SIZE 1	2	3	4	5	6	For Each Additional Dependent Add	Discounts based upon the "Highest Non-Governmental volume payer" UnInsured or Medicare	Discounts based upon the "Highest Non-Governmental volume payer" Underinsured
	$0	$0	$0	$0	$0	$0		100% Discount	100% Discount
Up to 200%	$25,520	$34,480	$43,440	$52,400	$61,360	$70,320	$8,960		
	$25,521	$34,481	$43,441	$52,401	$61,361	$70,321			
201% to 250%	$31,900	$43,100	$54,300	$65,500	$76,700	$87,900	$11,200	85% Discount	80% Discount
	$31,901	$43,101	$54,301	$65,501	$76,701	$87,901			
251% to 300%	$38,280	$51,720	$65,160	$78,600	$92,040	$105,480	$13,440	65% Discount	60% Discount
	$38,281	$51,721	$65,161	$78,601	$92,041	$105,481			
301% to 350%	$44,660	$60,340	$76,020	$91,700	$107,380	$123,060	$15,680	45% Discount	40% Discount
	$44,661	$60,341	$76,021	$91,701	$107,381	$123,061			
351% to 400%	$51,040	$68,960	$86,880	$104,800	$122,720	$140,640	$17,920	25% Discount	20% Discount