



Financial Assistance Program Policy and Procedure

Centralus Health System

As a service to our patients, hospital financial counselors are available to discuss whether or not a patient may qualify for publicly sponsored New York State & Federal health insurance programs. These programs include, but are not limited to Medicaid and Medicare. In addition to these insurance programs, Centralus Health System offers full or partial financial assistance to those individuals who are eligible based on income guidelines set forth in this policy.

Section 1 - Financial Assistance Program Policies

a - Costs and Services Eligible for Financial Assistance

Centralus Health System provides Emergency Care and Medically Necessary services, without regard to a patient's source of payment. Financial assistance is available for eligible patients (defined below) to help ease the burden of the cost of Emergency Care and Medically Necessary services they are provided, but the provision of that care will never be contingent on a patient's eligibility for the Financial Assistance Program (FAP).

Patients will not be denied admission or denied medically necessary treatment or services because of an unpaid medical bill.

Centralus Health System's Financial Assistance Policy applies to the following organizations:

Cayuga Medical Center	Arnot Ogden Medical Center
Schuyler Hospital	Ira Davenport Memorial Hospital
Cayuga Addiction Recovery Services	Fred & Harriet Taylor Health
Cayuga Medical Associates	St. Joseph's Hospital
Visiting Nurse Services	New Dawn Rehabilitation Services
Cayuga Health Transport	SJH Behavioral Science Unit
Arnot Medical Services	SJH Skilled Nursing

Definitions

Emergency Care:

As required by Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act (42 U.S.C. 1395dd), Emergency Care is care required as a result of a sudden onset of a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, that a prudent patient who possesses an average

knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the patient's health in serious jeopardy, or in the case of behavioral condition placing the health of such person or others in serious jeopardy,
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or body part, or
4. Serious disfigurement of the patient.

Medically Necessary Care:

Health services that are reasonably necessary to prevent illnesses or medical conditions, or provide early screening, diagnosis, intervention, and/or treatment for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of an Enrollee, or endanger life, which are provided at appropriate facilities and levels of care, consistent with accepted local health care practices and standards in literature, and which are not experimental or primarily for the convenience of the patient.

Services Not Eligible for Financial Assistance:

Financial assistance is only available for costs associated with Medically Necessary Care and therefore such discounts are not available to cover the costs of medically unnecessary care such as, but not limited to, cosmetic surgery, or other services that are provided primarily for the convenience of the patient, his/her family or provider.

b -Financial Assistance Eligibility Requirements

Financial assistance is available for uninsured and underinsured patients who reside in New York State in Centralus Health System's Primary or Secondary Service Area and whose household income is at or below 400% (see Appendix A) and of the most recent Federal Poverty Guidelines. Eligibility for financial assistance will not be determined by a patient's assets or immigration status. Per section 2807-k of the NYDOH regulations, patients can qualify for financial assistance under the following conditions:

1. Low income patients with no health insurance; or
2. Low income patients who have exhausted their insurance benefits; or
3. Low income patients who have an inability to pay co-pays and deductible amounts, at the hospital's discretion.

c - Determination of Patient Payment

Income Level	Payment
Below 200% FPL	Waive all charges

200% - 300% FPL	Uninsured patients: Sliding scale up to 10% of the amount that would have been paid for the services(s) by Medicaid. Underinsured patients: Up to a maximum of 10% of the amount that would have been paid pursuant to such patient's insurance cost sharing.
301% - 400% FPL	Uninsured patients: Sliding scale up to 20% of the amount that would have been paid for the services(s) by Medicaid. Underinsured patients: Up to a maximum of 20% of the amount that would have been paid pursuant to such patient's insurance cost sharing.

Residency Eligibility Criteria

To qualify for financial assistance you must live in Cayuga Health System's service area which includes the following counties: Cayuga, Chemung, Cortland, Schuyler, Tioga, Tioga Count in Northern PA, and Tompkins.

d-Determination of Poverty Levels – Income & Assets

Income - Income poverty levels must be updated and adopted annually by April 1st using the current year's income levels published on the US Department of Health and Human Services website: <http://aspe.hhs.gov/poverty-guidelines>

Assets – Assets will not be taken into account when determining FAP eligibility or level of sliding discount an eligible patient will receive.

e-Notification of FAP Availability

Patient

1. Patient must be uniformly notified by registration upon arrival that financial assistance is available. Patients will be notified with the provision of a financial assistance brochure that meets PLS standards (defined below) or the PLS itself.
2. Plain Language Summary (PLS) - A written statement which notifies the patient that the hospital offers financial assistance and provide additional info in a clear, concise, understandable manner and include the following:
 - a. Eligibility requirement and type of assistance offered
 - b. Brief Summary of how to apply for assistance
 - c. Website and physical location where an individual can obtain copies of FAP and FAP application form
 - d. Contact information of a source that may assist with form
 - e. Statement addressing the availability of translations

3. Brochures must be made available in plain sight (at a minimum in the ED & Admission areas) and produced upon request by the patient at no cost. Brochures must be updated whenever a substantial change to the FAP is made.

4. Website – website must be updated whenever there are significant changes to any of the following items:
 - a. PLS
 - b. Asset or Income Levels

f - Adoption Process for Financial Assistance Policy

Any substantive changes to the financial assistance policy must be approved and adopted by the Finance Committee of the hospital.

Section 2 - Financial Assistance Program Application Process

a - Government Assistance

In determining whether each patient qualifies for the Financial Assistance Program, other county, and state or federal financial assistance programs may be considered as options for the patient. A financial counselor will assist the patient in determining if they are eligible for any governmental assistance by utilizing the current guidelines provided by our local Department of Social Services. If a patient qualifies for state or federal assistance, but needs additional help paying for medical bills, the patient is allowed to apply for the hospital's financial aid program.

NOTE: New York State Health Care Law prohibits Centralus from requiring all patients to apply for State/Federal insurance programs (e.g. Medicaid) as a pre-requisite to apply for the FAP. Additionally, CHS is not allowed to delay the processing of FAP applications, when an applicant is waiting for an eligibility determination from a State/Federal insurance program. It is important Centralus facilitates the application to State/Federal insurance program for those patients who are likely to qualify, but FAP determinations should be paid independent of eligibility for State/Federal insurance programs.

b - Application Process

Any patient who indicates the financial inability to pay for Emergency Services or Medically Necessary services may apply for financial assistance.

Notification Period: The hospital will make a good faith effort to inform the patient financial assistance is available at any time during the collection process.

Application period: A patient will be allowed to apply for financial assistance any time during the collection process.

c - Availability of the Application

The patient may request an electronic and/or a paper copy of the application material at no cost to the patient.

d - Completion of Application

The patient is responsible for ensuring that his or her application is complete. The hospital is responsible, in accordance with IRS regulations, to provide assistance with said application. A completed application shall include all the necessary documentation outlined in this Financial Assistance Policy. Information provided on an application is subject to verification. Patients submitting incomplete applications or whose information cannot be verified will be notified in writing of the missing information or the verification problems and given 10 days to provide the requested information or verification.

1. **Household Income Criteria and Verification:** The evaluation of a patient's eligibility for the Financial Assistance program will be based upon a combination of the patient's household size and income (see Appendix A).
 - a. **Household size:** the number of family members or other persons occupying the same household who are identified as dependents for federal taxation purposes and any other individuals or significant others residing in the same household. This information will be self-reported and cannot be verified by requesting tax returns pursuant to NYS Department of Health Law 2807-k(9-a).
 - b. **Income:** annual earnings and cash benefits from all sources before taxes for the patient and anyone in the patient's defined household. Income shall include wages, interest, dividends, rents, pension, Social Security, VA benefits, unemployment benefits, worker's compensation, disability, child support, alimony and any other types of income that may accrue to the patient or any individual in the patient's defined household.
 - i. Income will be determined and verified based upon documentation of wages and/or other sources of income provided by the patient, such as pay stub or W2 (Tax returns or monthly bills cannot be requested under NYS Department of Health Law 2807-k(9-a)). Income may also be determined

by annualizing the pay of the patient and others in the patient's defined household, at the current reported earnings rate.

2. **Household Assets Criteria and Verification:** Assets will not be taken into consideration when determining a patient's eligibility for Financial Assistance
3. **Additional Verification of Application Information:** The hospital will not seek any other sources of information outside of what is requested of and provided by the patient. The hospital will not perform credit checks or any other 3rd party verification to verify information provided by the patient on the Financial Assistance Application. Individuals cannot be denied financial assistance if they do not provide documentation that has not been specified in this FAP policy.

e – Application Determination

A patient will be sent a written letter of determination within 30 days of the hospital's receipt of his or her completed application as to his or her eligibility for the Financial Assistance Program

f – Inquires

Hospital may make inquiries to, and obtain reports, from third parties such as credit agencies, on certain patients to determine whether they may be presumptively eligible (presumptive eligibility) for Financial Assistance under the following limited conditions:

1. The patient has been discharged from the hospital
2. The patient lacks insurance coverage, the coverage has been exhausted, or all benefit coverage has been applied to the account
3. The patient has received a least one statement and the time period for paying that bill has expired, and
4. The patient has not completed an application for Financial Assistance.
5. Credit Scoring obtained will not negatively impact the patient's FICO.
6. Credit Scoring will not be used to deny financial assistance.

g – Appeal Process

Any determinations made under this policy may be appealed in writing to Centralus Health System, Chief Financial Officer, 101 Dates Drive, Ithaca, NY 14850.

h – Effective Dates of FAP Eligibility

Start Date: The patient may apply for financial assistance any time during the collection process.

Expiration: From the date of approval, a patient's financial assistance application determination will be good for 12 months, at which time it will expire and the patient will have to reapply for future financial assistance. The patient will be provided with a card that will specify who is covered by the financial assistance application and what date their eligibility expires.

Section 3 - Provider Billing and Collection Efforts

a – Billing

Once a patient has submitted a completed application for the Financial Assistance Program, the patient may disregard any bill sent until the hospital has rendered a determination on the pending financial assistance application.

1. Billing statement must include a notice that financial assistance is available and provide a number and website to access more information about financial assistance
2. Installment payment plans may be established for patients who qualify for financial assistance. Monthly installment payments will be capped at 5% of gross monthly income of the patient's defined household. Centralus Health System may consider assets of a significant value when establishing the monthly payment amount and such assets may be a basis for increasing the monthly payment.

b – Collections

Extraordinary Collections Actions (ECAs) – including, but not limited to, reporting adverse information to credit bureaus or placing liens on property - cannot commence until at least 121 days after the 1st billing statement and requires that the patient be notified 30 days in advance with a pre-collect letter outlining what ECAs will occur and when.

Centralus Health will not initiate lawsuits against patients with incomes below 400% of the Federal Poverty Level.

Notification period: The hospital will make a good faith effort to inform the patient financial assistance is available any time during the collection process. A patient cannot be sent to collection until the period has ended.

Application period: A patient will be allowed to apply for financial assistance any time during the collection process. If a patient submits an application at any point during the application period the following will occur:

1. Complete application
 - a. Suspend ECAs
 - b. Provide eligibility determination within 30 days
 - c. Send written letter of determination
 - d. Provide an updated billing statement reflecting adjusted amount due (if the patient ends up being FAP eligible)
2. Incomplete application
 - a. Suspend ECSs
 - b. Send written letter notifying patient that their application is pending and what information is needed to proceed with determining their eligibility.

Section 4 – Updating, Execution, and Compliance

a – Updates:

The Compliance department, with assistance from and coordination with the Accounting Department & Patient Billing Department, will be responsible for updating this policy to meet the current needs of the hospital and regulatory requirements. Any substantive changes to the financial assistance policy must be approved and adopted by the Finance Committee of the hospital.

b- Execution

The patient billing department and/or contractors in coordination of Financial Counselors will be responsible for executing this FAP and assisting patients in understanding this FAP.

c – Compliance Audit

The Compliance Department with assistance from the Accounting and Patient Billing departments, will be responsible for completing an annual audit of the Financial Assistance Policy and Process to ensure the words of the policy and execution of the policy are in compliance with all relevant laws and regulations.

Appendix A

Centralus Health System Financial Assistance Matrix

Family Size, Income Levels, and Sliding Discount Schedule

Uninsured

Discount	100%	100%	100%	100%	100%	10% of Medicaid Rate	10% of Medicaid Rate	20% of Medicaid Rate
Upper Limit of % of Federal Poverty Level	100%	125%	150%	175%	200%	250%	300%	400%
	100% or Below	101-125%	126 - 150%	151-175%	176-200%	201-250%	251 - 300%	301 - 400%
1	\$ 15,060.00	\$ 18,825.00	\$ 22,590.00	\$ 26,355.00	\$ 30,120.00	\$ 37,650.00	\$ 45,180.00	\$ 60,240.00
2	\$ 20,440.00	\$ 25,550.00	\$ 30,660.00	\$ 35,770.00	\$ 40,880.00	\$ 51,100.00	\$ 61,320.00	\$ 81,760.00
3	\$ 25,820.00	\$ 32,275.00	\$ 38,730.00	\$ 45,185.00	\$ 51,640.00	\$ 64,550.00	\$ 77,460.00	\$ 103,280.00
4	\$ 31,200.00	\$ 39,000.00	\$ 46,800.00	\$ 54,600.00	\$ 62,400.00	\$ 78,000.00	\$ 93,600.00	\$ 124,800.00
5	\$ 36,580.00	\$ 45,725.00	\$ 54,870.00	\$ 64,015.00	\$ 73,160.00	\$ 91,450.00	\$ 109,740.00	\$ 146,320.00
6	\$ 41,960.00	\$ 52,450.00	\$ 62,940.00	\$ 73,430.00	\$ 83,920.00	\$ 104,900.00	\$ 125,880.00	\$ 167,840.00
7	\$ 47,340.00	\$ 59,175.00	\$ 71,010.00	\$ 82,845.00	\$ 94,680.00	\$ 118,350.00	\$ 142,020.00	\$ 189,360.00
8	\$ 52,720.00	\$ 65,900.00	\$ 79,080.00	\$ 92,260.00	\$ 105,440.00	\$ 131,800.00	\$ 158,160.00	\$ 210,880.00
9	\$ 58,100.00	\$ 72,625.00	\$ 87,150.00	\$ 101,675.00	\$ 116,200.00	\$ 145,250.00	\$ 174,300.00	\$ 232,400.00
10	\$ 63,480.00	\$ 79,350.00	\$ 95,220.00	\$ 111,090.00	\$ 126,960.00	\$ 158,700.00	\$ 190,440.00	\$ 253,920.00
11	\$ 68,860.00	\$ 86,075.00	\$ 103,290.00	\$ 120,505.00	\$ 137,720.00	\$ 172,150.00	\$ 206,580.00	\$ 275,440.00
12	\$ 74,240.00	\$ 92,800.00	\$ 111,360.00	\$ 129,920.00	\$ 148,480.00	\$ 185,600.00	\$ 222,720.00	\$ 296,960.00
13	\$ 79,620.00	\$ 99,525.00	\$ 119,430.00	\$ 139,335.00	\$ 159,240.00	\$ 199,050.00	\$ 238,860.00	\$ 318,480.00
14	\$ 8,500.00	\$ 106,250.00	\$ 127,500.00	\$ 148,750.00	\$ 170,000.00	\$ 212,500.00	\$ 255,000.00	\$ 340,000.00

Under Insured

Discount	100%	100%	100%	100%	100%	10% of Patient Cost Share	10% of Patient Cost Share	20% of Patient Cost Share
Upper Limit of % of Federal Poverty Level	100%	125%	150%	175%	200%	250%	300%	400%
	100% or Below	101-125%	126 - 150%	151-175%	176-200%	201-250%	251 - 300%	301 - 400%
1	\$ 15,060.00	\$ 18,825.00	\$ 22,590.00	\$ 26,355.00	\$ 30,120.00	\$ 37,650.00	\$ 45,180.00	\$ 60,240.00
2	\$ 20,440.00	\$ 25,550.00	\$ 30,660.00	\$ 35,770.00	\$ 40,880.00	\$ 51,100.00	\$ 61,320.00	\$ 81,760.00
3	\$ 25,820.00	\$ 32,275.00	\$ 38,730.00	\$ 45,185.00	\$ 51,640.00	\$ 64,550.00	\$ 77,460.00	\$ 103,280.00
4	\$ 31,200.00	\$ 39,000.00	\$ 46,800.00	\$ 54,600.00	\$ 62,400.00	\$ 78,000.00	\$ 93,600.00	\$ 124,800.00
5	\$ 36,580.00	\$ 45,725.00	\$ 54,870.00	\$ 64,015.00	\$ 73,160.00	\$ 91,450.00	\$ 109,740.00	\$ 146,320.00
6	\$ 41,960.00	\$ 52,450.00	\$ 62,940.00	\$ 73,430.00	\$ 83,920.00	\$ 104,900.00	\$ 125,880.00	\$ 167,840.00
7	\$ 47,340.00	\$ 59,175.00	\$ 71,010.00	\$ 82,845.00	\$ 94,680.00	\$ 118,350.00	\$ 142,020.00	\$ 189,360.00
8	\$ 52,720.00	\$ 65,900.00	\$ 79,080.00	\$ 92,260.00	\$ 105,440.00	\$ 131,800.00	\$ 158,160.00	\$ 210,880.00
9	\$ 58,100.00	\$ 72,625.00	\$ 87,150.00	\$ 101,675.00	\$ 116,200.00	\$ 145,250.00	\$ 174,300.00	\$ 232,400.00
10	\$ 63,480.00	\$ 79,350.00	\$ 95,220.00	\$ 111,090.00	\$ 126,960.00	\$ 158,700.00	\$ 190,440.00	\$ 253,920.00
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12	\$ 74,240.00	\$ 92,800.00	\$ 111,360.00	\$ 129,920.00	\$ 148,480.00	\$ 185,600.00	\$ 222,720.00	\$ 296,960.00
13	\$ 79,620.00	\$ 99,525.00	\$ 119,430.00	\$ 139,335.00	\$ 159,240.00	\$ 199,050.00	\$ 238,860.00	\$ 318,480.00
14	\$ 8,500.00	\$ 106,250.00	\$ 127,500.00	\$ 148,750.00	\$ 170,000.00	\$ 212,500.00	\$ 255,000.00	\$ 340,000.00

Appendix B



Patient Sticker

PLEASE PRINT IN BLUE OR BLACK INK.

NYS Uniform Hospital Financial Assistance Application

You may be eligible for hospital financial assistance to pay your bills if you are uninsured, if your insurance is exhausted, or if you have health insurance but have proof of paid medical expenses totaling more than 10% of your income. Completing this form will start your request for hospital financial assistance. This form is used by all hospitals in New York State.

This application must be printed in the primary¹ languages spoken by patients served by the hospital.

Patient Name (complete information that is applicable)

Patient Name (First, Middle, Last)		
Date of Birth (mm/dd/yyyy)		
Address	Apartment/Unit #	
City	State	Zip
Contact Phone #		
Parent/Guardian or Lawful Representative Name (if patient is a minor child or an incapacitated adult)		
Email Address (if any)		

Family Information:

Please list below all family members in your household. Your household includes yourself, your spouse or domestic partner, and any children or other dependents. For example, this would include everyone listed on the same tax return.

Gross income means your income **before** taxes are deducted.

Gross income can consist of work earnings (wages, salaries, tips, earnings from self-employment), unearned income (social security, disability, and unemployment benefits), contributions (funds from family or friends), and other sources of income (temporary assistance and supplemental security income).

Full Name	Relationship	Total Gross Income (Current)
	Self	

¹ "Primary languages" includes any language that is used to communicate in at least 5% of patient visits per year, or any language spoken by more than 1% of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems.

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The hospital may request you submit documentation as proof of income; examples of documentation might include a pay stub, a letter from your employer if applicable, or Form 1040.

Health Insurance Status

Do you have any form of health insurance, including Medicaid, Medicare, or private insurance through your employer or purchased on your own? Yes No

If you answered "No," would you like assistance in applying for any of these programs?

Yes No

Underinsured patients: people with insurance and high medical expenses. If you have insurance, please provide an estimate of the medical bills you paid in the past 12 months.

\$

The hospital may request you submit documentation as proof of paid medical expenses.

Patient/Responsible Party: If not the patient, list the name of the person signing the form and their authority to sign on behalf of the patient (e.g., spouse, parent, legal representative).

I understand that the information I submit may be subject to verification from external sources. I certify that the information is true and complete to the best of my knowledge.

Print Name	Date
Relationship to Patient	
Signature	

Mail Completed Application to your location of Medical Care:

Cayuga Medical Center
Attn: Financial Assistance
101 Dates Dr.
Ithaca, NY 14850
(607) 274-4400

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

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Minimum Eligibility and Guidelines

Application Timeline, Patient Rights, and Confidentiality

- You can apply for financial assistance at any point during the collection process.
- You do not have to make any payment to this hospital until you receive a decision on your application for financial assistance. Hospitals may not forward accounts to collection while your application is pending.
- If you are denied financial assistance, you have the right to appeal. Information on how to do so will be included in the hospital's notice you receive. You may have the right to appeal the amount of your financial assistance. The hospital will include information about how to appeal in their decision letter.
- Hospitals cannot send unpaid bills to a collection agency for at least 180 days after your first bill.
- Hospitals are prohibited from taking legal action, including filing lawsuits, to recover unpaid medical bills for patients below 400% of the federal poverty level. Poverty guidelines can be found here: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>
- Any information provided in this application will only be used by the hospital to determine your eligibility for financial assistance and will remain confidential to the extent permitted by law.
- A hospital cannot deny you medically necessary services because you have an outstanding medical bill.
- If you need assistance with this application, please contact:
 - Cayuga Medical Center, Cayuga Medical Associates, and Schuyler Hospital: (607) 274-4400
 - Arnot Health: (607) 737-7715
- If you need additional assistance with this application or help appealing a decision, you can reach out to Community Health Advocates: 888-614-5400.

Eligibility

Nothing limits a hospital's ability to establish patient eligibility for payment discounts at income levels higher than those specified below and/or to provide greater payment discounts for eligible patients than those required by Public Health Law. Additionally, immigration status shall not be an eligibility criterion for the purpose of determining financial assistance.

The following individuals are eligible:

- Low-income individuals without health insurance; or
- underinsured individuals (out-of-pocket medical costs accumulated in the past twelve months that amount to more than ten percent of such individual's gross annual income); or
- those who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges; or
- at the hospital's discretion, individuals who can demonstrate an inability to pay their co- pay and/or deductible can request a reduced or discounted payment.

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Individuals up to 400% of the federal poverty level are eligible for financial assistance.

Federal Poverty Levels (2025)			
Household Size	200%	300%	400%
1 Person	\$31,300	\$46,950	\$62,600
2 Persons	\$42,300	\$63,450	\$84,600
3 Persons	\$53,300	\$79,950	\$106,600
4 Persons	\$64,300	\$96,450	\$128,600
5 Persons	\$75,300	\$112,950	\$150,600
6 Persons	\$86,300	\$129,450	\$172,600
7 Persons	\$97,300	\$145,950	\$194,600

 Updated annually: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

Minimum Discount Rates

If you qualify for financial assistance, your charges will be reduced according to your income on a sliding fee scale as follows:

Income Level	Payment
Below 200% FPL	Waive all charges
200% - 300% FPL	Uninsured patients: Sliding scale up to 10% of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 10% of the amount that would have been paid pursuant to such patient's insurance cost sharing.
301% - 400% FPL	Uninsured patients: Sliding scale up to 20% of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 20% of the amount that would have been paid pursuant to such patient's insurance cost sharing.

Hospitals may choose to provide greater discounts for eligible patients and/or offer payment discounts for patients at higher income levels.

Installment Plans

Installment plans are available to patients who are unable to pay the reduced rate all at one time. Monthly payments cannot exceed 5% of your gross monthly income and the rate of interest charged to the patient on the unpaid balance, if any, shall not exceed 2%.

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Request for Proof of Household Income

Please include the income information for the patient, their spouse, and any dependents (such as children). For example, this would include everyone on the same tax return (tax filer, spouse, and tax dependents) in the calculation of household income.

The following is a list of documents you can use to prove your income. You do not have to provide all these documents. You can also provide a statement of no household income if you have no income.

You may also provide the Eligibility determination page from the NY State of Health Marketplace. If you have this document, you do not have to provide any other income information listed below to the hospital.

<u>If Household Receives:</u>	<u>Amount per Month:</u>	<u>Applicant May Provide:</u>
Wages	\$	Please provide one Paycheck Stub, or Letter from Employer on company letterhead, signed and dated, or most recently filed income tax return.
Social Security Payment	\$	Copy of award letter/certificate, or correspondence from the U.S. Social Security Administration, or annual benefit letter. To request a copy of your Social Security benefit letter, call 1-800-772-1213 or visit www.ssa.gov .
Unemployment Compensation	\$	Copy of award letter/certificate, or monthly benefit statement from NYS Department of Labor, or Copy of Direct Payment Card with printout, or Correspondence from the NYS Department of Labor, or Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us).
Disability Payment	\$	Copy of award letter/certificate, or correspondence from Social Security Administration, or copy of annual benefit letter. To request a copy of your benefit letter, call 1-800-772-1213 or visit www.ssa.gov .
Workers Compensation	\$	Copy of Award Letter or Check stub.
Alimony/Child Support	\$	Copy of court order, or 3 months of cashed checks/receipts.
Dividends/Interest	\$	Quarterly dividend statements or 1 month statements.
Other	\$	Letter stating the amount of non-wage earnings (if any), such as rental income, cash for odd jobs, etc.
No Income	\$0	Signed statement of no income.