THE University of Vermont HEALTH NETWORK
Elizabethtown Community Hospital

Financial Assistance Program
75 Park Street, Elizabethtown , NY 12932
518-873-6377
Fax: 518-873-3097

Dear Applicant,

Thank you for choosing The Elizabethtown Community Hospital as your health care provider.

If payment of your medical bills creates a financial hardship for you, you may be eligible for financial assistance through Elizabethtown Community Hospital's Patient Financial Assistance Program. Our staff are here to help you and are willing to work through the process with you. Please note that before any financial assistance can be provided by Elizabethtown Community Hospital, our staff will work with you to identify other sources of payment.

The following criteria must be met to be eligible for financial assistance from Elizabethtown Community Hospital

- You must be a permanent resident within the eligibility area - Essex County, Washington County, Clinton County and Warren County New York or you may be from outside this service area AND received emergency care.
- The services that were provided to you must be considered medically necessary essential health care services.
- The following types of services are **not** eligible for financial assistance
  - Cosmetic services - unless medically necessary based upon diagnosis with physician review
  - Birth control, infertility treatments, fertility services, sterilization and reversal of sterilization.
  - Services that have been placed in Collections beyond 120 days of placement
  - General dentristy unless extenuating circumstances are presented by the dental practice
  - Services to residents outside of the financial eligibility area unless provided in an emergency room setting
  - Services reimbursed directly to you by your insurance carrier or already covered by a third party
- Household income must be within guidelines

During the time your application is being processed, please disregard any bills you received from Elizabethtown Community Hospital. We will not forward eligible accounts to collections while your application is pending. You have 30 days to return your application. If your application is not received during that time, we will resume normal collection efforts on your accounts.

If you meet the criteria and wish to apply for Elizabethtown Community Hospital's Patient Financial Assistance Program, please complete the enclosed application form. Please note, you will continue to be financially responsible for all services you receive until it is determined you qualify for assistance.

We are here to help, if you have any questions or require aid in understanding any part of the application process please contact the Financial Counselor at 518-873-3139 Completed applications should be forwarded to the following address:

Elizabethtown Community Hospital
Financial Counselor
PO Box 277
Elizabethtown, NY 12932

Form 036685 - Implemented March 26, 2018

For Your Convenience - Our Documentation Check List

To determine if you qualify for assistance, you will need to show proof of your income, and also supply documentation necessary for determination. Please fill out the attached application in full, sign it, and send the application along with a copy of each of the following documentation (those that are applicable) for your household:

Note: If sending Bank Statement or Online documentation, copies must include the bank name, client name, balance and current date.

1) Copies of three (3) consecutive paystubs or a letter from your employer indicating all gross income for the past three months or your latest IRS tax return is also acceptable. ☐

2) One (1) form of identification ☐

3) One (1) proof of residency (NYS driver's license, property tax bill, lease for property or a utility bill ☐

4) A Medicaid determination letter must accompany your application if your monthly gross income is lower than 138% of the Federal Poverty Guideline. In 2018, for an individual, that is $1,396. For married/household of two that is $1,893. ☐

5.) Copy of unemployment benefits statement if applicable (e.g., check, bank statement, online, etc.) ☐

6.) Copy of disability compensation benefit statement/award letter (e.g., check, bank statement, online, etc.) ☐

7.) Copy of social security, pension, retirement income (e.g., award letter, check stub, bank statement, etc.) ☐

8.) Documentation of child support and/or alimony paid or received (e.g.,cancelled check, garnishment, bank statement, etc.) ☐

9.) Rental Income ☐

10.) If an application for state assistance, (e.g. Medicaid, State Health Exchange) has been made in the last 60 days and you have received a decision, please provide a copy. Required during open enrollment. ☐

11.) Other: _____ ☐

Please use the above checklist to be sure we have all the information we need to quickly and correctly process your application. It is important that your application be complete, and that all necessary documentation is received. All information you provide to us is confidential.

Questions & Answers and Information You Should Know…, continued

My employer does not provide pay stubs, what should I do?

If pay stubs are not provided by your employer, an affidavit on letterhead from the company you work for will be accepted. The affidavit must show gross pay, deductions, and net pay for one month. Please note, if you are married or have a civil union partner, his / her verification is also required.

I do not complete a quarterly profit and loss for my business. Can I just send my current Federal Tax Return?

If you are a self employed sole proprietor, Partnership, or Corporation, you will need to provide us with the most current Federal Tax Return and the current year quarterly profit and loss statement. Even though your business may not complete a profit and loss, it is a requirement when you apply for the Patient Financial Assistance Program. If you are filing as a Partnership or Corporation we will need these Federal Tax Returns, your personal Federal Tax Returns, along with the Partnership and/or Corporation Year-to-Date, Quarterly Profit and Loss.

What is the coverage period for Patient Financial Assistance?

Financial Assistance is valid for up to six months and may include coverage to current balances unless otherwise noted. Your coverage period will be indicated on your grant letter. If your income indicates you may be eligible for Medicaid, NY Family Health Plus or another insurance program funded by the State, you will only be granted financial assistance for current charges until a Medicaid application is made and a notice of decision letter is received by the Financial Counselor. If you are over the age of 65 and are on a fixed income, you may be granted coverage up to one year.

How often do I need to re-apply for financial assistance?

The Patient Financial Assistance Program at Elizabethtown Community Hospital is not an insurance company or a program such as Medicaid, or NY Family Health Plus. We are here to assist patients who face financial hardship and are unable to pay their bills. Financial Assistance should only be applied for if you have outstanding medical bills you cannot pay, expectation that an account currently pending insurance will leave a balance, or expectation that a future scheduled service will leave you a balance.

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Elizabethtown Community Hospital

Financial Assistance Application

Applicant's Information:

Applicant Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Address	City	State	Zip code	Home Phone Number	Medical Record #

Employer — or check one: ☐student ☐unemployed ☐disabled ☐retired

Marital Status - please check one: ☐single ☐married ☐separated ☐divorced ☐widowed

Spouse Last Name	Spouse First Name	Middle Initial	Social Security Number	Date of Birth

Spouse Employer — or check one: ☐student ☐unemployed ☐disabled ☐retired

Household Information:

Please list below all dependents who live in your household. Do not include non-dependents who reside in your household.
Note: You may include dependents for which you provide at least 50 % support and who are reflected as dependents on your Federal Income Tax Returns.

Last Name	First Name	Social Security #	Relation to Applicant	Date of Birth

Additional Information:

Are you covered under any health insurance policy? ☐Yes ☐No

If yes, list insurance(s): _____

If no, answer next question:

Did you enroll with NY Health Exchange/Medicaid? ☐Yes ☐No

Date: _____ Final eligibility determination letter will be required.

If no, reason: _____

Do you reside in New York greater than 6 months per year? ☐Yes ☐No

Do you have outstanding balances with any of The UVM Health Network partners?

o UVMMC o Alice Hyde o CVMC o CVPH o Porter ☐Yes ☐No

Income

Monthly Income From:	Person 1	Person 2	
Name of household member:			Supporting Documentation
Gross Salary Wages	$	$	2 consecutive pay stubs / employer pay statement / tax return
Self Employed	$	$	Current YTD Profit & Loss
Social Security	$	$	Award letter, check stub, bank statement, etc
Workers' Compensation	$	$	Check, bank statement, online, etc
Unemployment	$	$	Check, bank statement, online, etc
Alimony / Child Support	$	$	Cancelled check, garnishment, bank statement, etc
Pension / Retirement Income	$	$	Bank Statement or Pension check stub
Disability	$	$	Check, bank statement, online, etc
Rental Income	$	$	Schedule E of IRS tax form
Dividend Income	$	$	Current/quarterly statement from financial institution
Other Income:	$	$	Contact PAP Specialist
Total:	**$**	**$**	

Please Read Carefully

I am requesting financial assistance from Elizabethtown Community Hospital. I verify that all information I have provided is accurate and complete. Elizabethtown Community Hospital has my permission to pursue verification of pertinent information and any incorrect, incomplete or false information provided may cancel my application for financial assistance. I agree to repay the full financial assistance award if I receive payment of any kind for the medical services covered by this finanical assistance application.

Signature of Patient (or Parent / Guardian if Patient is under 18) Date

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2018 Income Guidelines

To be eligible for financial assistance from Elizabethtown Community Hospital, your income should be at or below the yearly guidelines below. If your income exceeds the guidelines (350%) but you have extenuating circumstances, an application may be considered when submitted with a letter explaining your extenuating circumstances.

You must be a permanent resident within Elizabethtown Community Hospital's service areas: **Essex County, Washington County, Clinton County and Warren County New York**

In order to manage our resources responsibly and to allow Elizabethtown Community Hospital to provide the appropriate level of assistance to the greatest number of persons in need, Elizabethtown Community Hospital has implemented a policy with guidelines to provide assistance based upon a sliding fee scale. Balances after the financial assistance percentage have been applied shall remain the responsibility of the patient and shoud be paid promptly.

2018 FPG					
Persons In Family	**100%**	**200%**	**250%**	**300%**	**350%**
1	$12,140	$24,280	$30,350	$36,420	$42,490
2	$16,460	$32,920	$41,150	$49,380	$57,610
3	$20,780	$41,560	$51,950	$62,340	$72,730
4	$25,100	$50,200	$62,750	$75,300	$87,850
5	$29,420	$58,840	$73,550	$88,260	$102,970
6	$33,740	$67,480	$84,350	$101,220	$118,090
7	$38,060	$76,120	$95,150	$114,180	$133,210
8	$42,380	$84,760	$105,950	$127,140	$148,330
Patient Liability as a % of AGB	0%	25%	50%	75%	100%