



Community Memorial

150 Broad Street
Hamilton, NY 13346

Quality Care, Close to Home

Financial Assistance Policy – Plain Language Summary

Community Memorial Hospital provides emergency care and medically necessary health services without regard to a patient's ability to pay. Financial Assistance is available for eligible patients to help defray the cost of these services.

Eligible Services: Emergency Care means those services that are delivered in the Emergency Department. Medically Necessary Services are those services that are necessary to prevent, diagnose, or treat conditions that cause acute suffering, endanger life, or result in illness or infirmity. Financial Assistance is **not available** for Swing Bed Services. The primary service areas covered by our Financial Assistance Program are the counties of Chenango, Cortland, Madison, Oneida, Onondaga, Oswego and Otsego, in addition to all residents of New York State. Financial Assistance is also available to eligible patients to decrease the cost of deductibles, coinsurance, and co-payments, with the exception of services provided in the hospital based physician primary care offices.

Eligible Patients: Patients receiving eligible services, who submit a completed Financial Assistance Application, and who are determined eligible by the Community Memorial Hospital Financial Counseling Office.

How to Apply: Applications for Financial Assistance may be obtained as follows:

- Obtain an application in person at Community Memorial Hospital Registration or Financial Counseling Office, online at <http://www.communitymemorial.org/financial-assistance/>, request by mail by calling 315 824 6553 or send request in writing to Community Memorial Hospital, 150 Broad Street, Hamilton NY 13346.
- Return completed applications with required proof of income to Community Memorial Hospital, Attention: Financial Counseling Department, 150 Broad Street, Hamilton, NY 13346.

Determination of Financial Assistance Eligibility – Generally, patients are eligible for financial assistance based on their household income levels, as compared to the federal poverty guidelines. Assistance ranges from 100% write-off of charges to the Hospital's "**Amounts Generally Billed**" or "**AGB.**" **AGB** means the amounts generally billed to insured individuals and is calculated based on all claims allowed by Medicare and private health insurers over a 12 month period, divided by the associated gross charges for those claims. See attached for Financial Assistance Summary and Application materials.

Community Memorial Hospital
150 Broad Street
Hamilton, NY 13346

2021 Financial Assistance Program Summary

Emergency and medically necessary services covered by this program are:

- | | |
|---------------------------------|--|
| 1. Admitted acute care patients | 4. Referred ambulatory patients |
| 2. Emergency services patients | 5. Observation patients |
| 3. Ambulatory Surgery patients | 6. Hospital based physician office patients (uninsured patients only) |

Note: This program is not available for Swing Bed Services

Financial Assistance is also available to eligible patients to decrease the cost of coinsurance, co-payments and deductibles, **except at the hospital based physician offices.**

The amount of reduction in charges will be based on the most current Health & Human Services Guidelines. The following chart is based on the number of persons in the household and individual or household income of 100% to 375% of the Federal Poverty Level (FPL).

Discount Levels (based on FPL chart below):

Uninsured (No Insurance):

% discount of AGB	100%	75%	50%	25%	AGB*
-------------------	------	-----	-----	-----	------

Underinsured (After Insurance): ***Hospital accounts only**

% discount on deductibles, copay, or coinsurance balances only	100%	50%	25%
--	------	-----	-----

Persons in Family Unit	100 - 150% FPL	151 - 175% FPL	176 - 200% FPL	201 - 250% FPL	251 - 375% FPL
1	12,880 - 19,320	19,321 - 22,540	22,541 - 25,760	25,761 - 32,200	32,201 - 48,300
2	17,240 - 26,130	26,131 - 30,485	30,486 - 34,840	34,841 - 43,550	43,551 - 64,650
3	21,960 - 32,940	32,941 - 38,430	38,431 - 43,920	43,921 - 54,900	54,901 - 82,350
4	26,500 - 39,750	39,751 - 46,375	46,376 - 53,000	53,001 - 66,250	66,251 - 99,375
5	31,040 - 46,560	46,561 - 54,320	54,321 - 62,080	62,081 - 77,600	77,601 - 116,400
6	35,580 - 53,370	53,371 - 62,265	62,266 - 71,160	71,161 - 88,950	88,951 - 133,425
7	40,120 - 60,180	60,181 - 70,210	70,211 - 80,240	80,241 - 100,300	100,301 - 150,450
8	44,660 - 66,990	66,991 - 78,155	78,156 - 89,320	89,321 - 111,650	111,651 - 167,475
Add for each additional person	4,540 - 6,810	6,811 - 7,945	7,946 - 9,080	9,081 - 11,350	11,351 - 17,025

* "Amounts Generally Billed" or "AGB" means the amounts generally billed to insured individuals. The AGB percentage is calculated by Community Memorial Hospital based on all claims allowed by Medicare and private health insurers over a 12 month period, divided by the associated gross charges for those claims.

Specific documentation requested for **each member of the household**:

1. Last 4 consecutive weeks of pay stubs (2 if paid bi-weekly).
2. Proof of income from unemployment, Social Security, pension, Worker's Compensation, disability, etc.
3. For self-employed persons, complete attached Self-Attestation form or submit a 3 month business ledger. (A tax return is optional.)

Any resident of Chenango, Madison, Oneida, Onondaga, Oswego, and Otsego counties, and all residents of New York State that receive services at Community Memorial Hospital are eligible to apply for this program. Please complete and return the attached application with requested documentation to the address above.

Questions regarding this policy may be directed to the Community Memorial Hospital Financial Counseling Office at 315-824-6552 or 315-824-6553.



Community
Memorial

Self-Attestation of Income

This form should be used by patients and members of their households, 18 years and older, who have no other type of documentation to verify their income.

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

- I get paid in cash and do not receive a pay stub; amount per month \$ _____
- I am unemployed and have no income
- I am self-employed; please complete below or submit most recent tax return

Self-employment income; *indicate your net monthly income after business expenses are subtracted:*

\$ _____

I certify that I have no other way to document the above income. I affirm that the income information provided is true, complete, and correct to the best of my ability.

Signature: _____ Date: _____