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 accounts in bad debt. 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.

**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. Any patients who qualify for Medicaid or other governmental health insurance coverage on the basis of their income will be required to apply as a condition of receiving Financial Assistance. Please see our Financial Assistance Policy for further details or contact our Financial Counseling Department at 315-824-6553 for further details.

**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 6552 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 a nominal fee 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

### 2024 Financial Assistance Program Summary

## Emergency and medically necessary services covered by this program are:

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

**Note: This program is not available for accounts that are in bad debt.**

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 400% of the Federal Poverty Level (FPL).

**Discount Levels (based on FPL chart below):**

Uninsured (No Insurance):

| *% discount of AGB* | 80% | 75% | 50% | 25% | AGB* |
|---|---|---|---|---|---|

Underinsured (After Insurance):

| *% discount on deductibles, copay, or coinsurance balances only* | 80% | 75% | 50% | 25% | 10% |
|---|---|---|---|---|---|

| Persons in Family Unit | 100 - 150% FPL | 151 - 200% FPL | 201 - 250% FPL | 251 - 300% FPL | 301 - 400% FPL |
|---|---|---|---|---|---|
| 1 | 15,060 - 22,590 | 22,591 - 30,120 | 30,121 - 37,650 | 37,651 - 45,180 | 45,181 - 60,240 |
| 2 | 20,440 - 30,660 | 30,661 - 40,880 | 40,881 - 51,100 | 51,101 - 61,320 | 61,321 - 81,760 |
| 3 | 25,820 - 38,730 | 38,731 - 51,640 | 51,641 - 64,550 | 64,551 - 77,460 | 77,461 - 103,280 |
| 4 | 31,200 - 46,800 | 46,801 - 62,400 | 62,401 - 78,000 | 78,001 - 93,600 | 93,601 - 124,800 |
| 5 | 36,580 - 54,870 | 54,871 - 73,160 | 73,161 - 91,450 | 91,451 - 109,740 | 109,741 - 146,320 |
| 6 | 41,960 - 62,940 | 62,941 - 83,920 | 83,921 - 104,900 | 104,901 - 125,880 | 125,881 - 167,840 |
| 7 | 47,340 - 71,010 | 71,011 - 94,680 | 94,681 - 118,350 | 118,351 - 142,020 | 142,021 - 189,360 |
| 8 | 52,720 - 79,080 | 79,081 - 105,440 | 105,441 - 131,800 | 131,801 - 158,160 | 158,161 - 210,880 |
| Add for each additional person | 5,380 - 8,070 | 8,071 - 10,760 | 10,761 - 13,450 | 13,451 - 16,140 | 16,141 - 21,520 |

* "**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.

**COMMUNITY MEMORIAL HOSPITAL**
FINANCIAL COUNSELING DEPARTMENT
150 BROAD STREET
HAMILTON, NY 13346

# REQUESTS FOR DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE

**PLEASE RETURN THIS FORM AND DOCUMENTATION REQUESTED TO THE ABOVE ADDRESS WITHIN 30 DAYS. YOU WILL RECEIVE NOTIFICATION WITHIN 30 DAYS FROM THE RECEIPT OF YOUR APPLICATION STATING WHETHER YOU HAVE BEEN APPROVED AND THE LEVEL OF DISCOUNT RECEIVED. IF YOUR APPLICATION IS DENIED YOU MAY FILE AN APPEAL BY CONTACTING THE VICE PRESIDENT OF FINANCE AT 315-824-6560. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE IN COMPLETING THIS APPLICATION, PLEASE CONTACT FINANCIAL COUNSELING AT 315-824-6552 OR 315-824-6553.**

DATE OF REQUEST: _____

PATIENT'S NAME _____
LAST FIRST MIDDLE

RESPONSIBLE PARTY (IF PATIENT IS A MINOR): _____

ADDRESS: _____

PHONE NUMBER: _____ DATE OF BIRTH: _____

EMPLOYER: _____ OCCUPATION: _____

INCOME PROOF:
_____ LAST 4 CONSECUTIVE WEEKS OF PAY STUBS, 2 IF PAID BI-WEEKLY
_____ PROOF OF INCOME FROM UNEMPLOYMENT, SOCIAL SECURITY, PENSIONS, WORKER'S COMPENSATION, DISABILITY, ETC.
_____ FOR SELF-EMPLOYED PERSONS, A 3 MONTH BUSINESS LEDGER OR SELF-ATTESTATION FORM (A TAX RETURN IS OPTIONAL)

| **LIST HOUSEHOLD INCOME** | **TOTAL FOR LAST MONTH** | | | |
|---|---|---|---|---|
| | **PATIENT** | **SPOUSE OR PARTNER** | **PARENT** (IF PATIENT IS A CHILD) | **TOTAL** |
| WAGES | | | | |
| FARM/SELF EMPLOYED | | | | |
| SOCIAL SECURITY | | | | |
| UNEMPLOYMENT | | | | |
| ALIMONY/CHILD SUPPORT | | | | |
| DISABILITY | | | | |
| WORKERS' COMPENSATION | | | | |
| DIVIDENDS/INTEREST/RENTALS | | | | |
| MILITARY ALLOTMENT | | | | |
| PENSION | | | | |
| ALL OTHER INCOME | | | | |

**HOUSEHOLD SIZE**—PLEASE BE SURE LIST **ALL HOUSEHOLD MEMBERS** AND INCLUDE **ANY DEPENDENT CHILDREN WITH AGES**

| NAME | RELATIONSHIP | NAME | RELATIONSHIP |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

DATE: _____ SIGNATURE: _____

**NO PAYMENT IS REQUIRED DURING THE REVIEW PROCESS UNTIL YOU RECEIVE A DETERMINATION FROM THIS OFFICE.**

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: _____