Carthage Area Hospital

Dear Carthage Area Hospital Patient:

I have enclosed an application for financial assistance at Carthage Area Hospital. Financial assistance, in the form of a sliding scale charity discount, is available to residents of New York State only. Consideration for financial assistance will apply to eligible services that are considered essential health services provided and billed under Carthage Area Hospital. Please be advised the financial assistance does not cover convenience items (telephone or television service), elective cosmetic services, services provided by a private, interpreting physician group, denture, crown, implants, and Invisalign related services. Please review and complete all questions, as the determination for eligibility is based on the information provided. We will need copies of the following where applicable:

1. Copies of last four (4) consecutive weeks of pay stubs (two (2) if paid bi-weekly).
2. Copies of four (4) of your most recent unemployment stubs, if not working.
3. For self-employed persons, a three (3) month business ledger or self- attestation form (a tax return is optional).
4. Medicaid eligibility status (is available from having recently applied).
5. Copy of Social Security/Disability income statement. If direct deposit, please provide a copy of your bank statement.
6. Where no type of income documentation is available the self-attestation form may be used.

If you have a financial or personal situation you would like taken into consideration, please include a letter with your application.

Please return your completed application to the Patient Accounting Department at the address located on the bottom of the application within thirty (30) days.

**** Once a completed financial assistance program application has been received by Carthage Area Hospital you may disregard any billing statements until a determination of eligibility has been made.**

If you have any question, please contact Patient Accounting Department at (315) 493-1000 Ext. 3343.

Sincerely,

Billing Clerk

Carthage Area Hospital Financial Assistance Program Application

Patient's Name_____ _____ ____ _____
First Last MI Date of Birth

Address_____ _____ _____ _____
Street City State Zip Code

Phone_____ Household Size _____

Household Information

(Please include everyone residing in the household including the applying patient)

Name Date of Birth Relationship to Patient

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Income

(Please check appropriate box for source of income and enter monthly or annual dollar amount)

	Patient	Spouse	Parents (if patient is a child)	Monthly Income	Annual Income
Wages				$	$
Social Security				$	$
Pension				$	$
Disability				$	$
Unemployment				$	$
Workers Comp				$	$
VA Benefits				$	$
Child Support				$	$
Alimony				$	$
Rental Income				$	$
Interest Dividends				$	$
Other Income				$	$

I certify that the above information is true and accurate to the best of my knowledge.

Signature _____ Date_____

Upon submitting a completed application, you may disregard any bills until you receive notification of a determination of your application. The applicant will have ninety (90) days from the date of service to request an application and thirty (30) days to submit the completed application. A decision regarding the application will be made within thirty (30) working days. Applicants will be notified by letter of the decision. Applicants may request a review of denial or partial denial within thirty (30) days from the denial notice. Applicants wishing to appeal the denial may do so by requesting so in writing with additional documentation or any financial or personal situation that they would like taken into consideration.

Carthage Area Hospital

SELF ATTESTATION OF INCOME

This form should be used by patients 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

- I am self-employed

Please indicate your gross monthly income: $ _____

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: _____

*1001 West Street * Carthage, New York 13619 * (315) 493-1000 * Fax: (315) 493-0105*