Please Indicate what facility(s) you are applying for:

- ☐ Carthage Area Hospital
- ☐ Claxton-Hepburn Medial Campus
- ☐ Claxton-Hepburn Medical Center
- ☐ North Country Orthopedic Group

Date:_____

Dear Applicant:

Enclosed is an application for financial assistance for a North Star Health Alliance Facility.
We are committed to providing high-quality care, regardless of financial circumstances. We understand that medical costs can be a concern, and we want to help you access the care you need without undue financial hardship. 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:

- Proof of income including (1) pay stub for each employer.
- Pension Statement of Benefits.
- Social Security Statement of Benefits.
- Disability Payments.
- Worker's Compensation Benefits.
- If self-employed, an income attestation and cash flow statement from an accountant/bookkeeper is required.
  OR
- 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.

Please DO NOT send copies of state or federal tax returns unless requested.

We will process your application within 30 working days of receipt of your completed application along with the above document request. After we process your complete application, we will notify you in writing the amount due to Carthage Area Hospital. Your first installment payment or payment in full is due within 30 days from the date of the letter sent to you. We want to work with you to help you get your bills paid to the hospital.

Please mail Financial Application and requirements to:
Carthage Area Hospital, Financial Assistance Clerk, 1001 West Street Carthage, New York 13619
Claxton-Hepburn Medical Campus, Financial Assistance Counselor, 214 King Street, Ste A, Ogedensburg, New York 13669
Claxton-Hepburn Medical Center, Financial Assistance Counselor, 214 King Street, Ste B, Ogedensburg, New York 13669
North Country Orthopaedic Group, Financial Assistance Clerk, 1571 Washington Street, STE 201, Watertown, New York 13601
Or
Email to patientfinancialsupport@nshany.org

If you have any questions, please contact the Patient Accounting Department:
Carthage Area Hospital and Clinics (315) 519-5715
Claxton-Hepburn Medical Campus and Claxton-Hepburn Medical Center (315)713-5147 or (315) 713-5139
North Country Orthopaedic Group (315) 836-2113

You may also call Community Health Advocates at 888-614-5400 for help appealing a decision or application questions or you may contact the New York State Department of Health at 1-800-804-5447 with regard to any denial.

Thank you for trusting North Star Health Alliance with your care.

Sincerely,
North Star Health Alliance /Financial Assistance Department

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.

Patient Name (complete information that is applicable)

Patient Name (First, Middle, Last)		MRN
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 (Current)**	**Total Gross Income**
	Self	

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	

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 our Financial Assistance team at:
  Carthage Area Hospital (315) 519-5715
  Claxton-Hepburn Medical Campus and Claxton-Hepburn Medical Center (315) 713-5147 or (315) 713-5139
  North Country Orthopaedic Group (315) 836-2113
- If you need 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.

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 Person	$42,300	$63,450	$84,600
3 Person	$53,300	$79,950	$106,600
4 Person	$64,300	$96,450	$128,600
5 Person	$75,300	$112,950	$150,600
6 Person	$86,300	$129,450	$172,600
7 Person	$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. Under insured 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. Under insured 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%.

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.

If Household Receives:	Amount per Month:	Applicant May Provide:
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.

NEW YORK STATE DEPARTMENT OF HEALTH

Office of Health Insurance Programs

Self- Declaration of Income

Name:_____ **App Reg./Case#:**_____ **Social Security Number:**_____

Address: _____ **City:**_____ **State:**_____**Zip Code:** _____

Complete the information below only if you have no other way to document your income. All of the boxes below must be checked and all questions answered. Failure to complete this form may result in denial of your application.

☐ I get paid in cash.

☐ I do not get pay

☐ checks. I do not

get pay stubs.

☐ I cannot get a letter from my employer. **Explain why**: _____

_____

My cash income is $_____ How often (weekly, monthly etc.) _____

Current Employer:

_____

Applicants/Recipients must read the following and sign below

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for Public Health Insurance Programs. I understand that program officials may verify information on this form. I also understand that if I intentionally misrepresent my income, I may have to repay benefits received and may be prosecuted under State law.

Signature of Applicant: _____ Date: _____

Facilitated Enrollers must read the following and sign below

I certify that I asked the applicant/recipient about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me. I did not modify the information in any way. I understand that if I intentionally falsified information on this form or if I assisted the applicant in falsifying any information, I may lose my job and may be prosecuted under State law.

Name: _____ Signature: _____ Date:_____.