MARY'S AVE CAMPUS	BROADWAY CAMPUS	MARGARETVILLE HOSPITAL

Application for Hospital Financial Assistance
(Completed application must be submitted within 20 working days with proof of income and required documentation. See page 3 for a list of required documentation)

Name:	Street Address:	City, State, Zip
Soc Sec #:	Phone (home/cell)	Phone (work)

Hospital Account#	Hospital Account#	Hospital Account#	Hospital Account#
Balance due $	Balance $	Balance $	Balance $

Have you applied for Medicaid? ________ Yes ________No If no, why not? ________________

____

Briefly describe your financial situation: ____

DEPENDENTS:____

Name	Age	Relationship

ANNUAL INCOME:

Patient Income:	Spouse Income:	Other Family Members' Income:
Social Security:	Pension:	VA Benefits:
Alimony:	Child Support:	Public Assistance:
Unemployment:	Compensation:	Other:

NOTE: Proof of household income, such as the last 4 pay stubs, current Social Security award letter, Identity and two proofs of residency (utility bill, cable, rent receipt, copy of lease or notarized letter from landlord or person you reside with) MUST be enclosed with this application. Please see page 3.

I certify that the above information is true and accurate to the best of my knowledge. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and require full and immediate payment of this debt.

I give my permission to HealthAlliance of the Hudson Valley to disclose this information to any Federal or State agency responsible for determining program compliance.

______________________________ ______________________________

Date of Request Applicant's Signature

INDIVIDUAL NOTICE OF AVAILABILITY OF FINANCIAL ASSISTANCE 2022

HealthAlliance of the Hudson Valley provides a reasonable amount of its services at a reduced charge or no charge to eligible persons who request those services. Financial Assistance will be available to persons whose family income are not greater than the Federal Poverty Income Guidelines listed below, and apply to hospital bills only. Private physician fees are not covered under this program

2022 CALCULATION OF INCOME LEVELS FOR DETERMINING CHARITY CARE

Persons in Family Unit	48 Contiguous US States and D.C.	Level I	Level II		Level III		Level IV
		< = 250% FPL	251% - 350% FPL		351% - 500% FPL		OOP > 20% of Income
		100% Discount	50% Discount		30% Discount		50% Discount
			Between…		Between…		
		250%	**251%**	**350%**	**351%**	**500%**	
1	$13,590	$33,975	$33,976	$47,565	$47,566	$67,950	Family Income multiplied by 20% to determine maximum out-of-pocket expense to be incurred. Once reached, then 50% discount
2	$18,310	$45,775	$45,776	$64,085	$64,086	$91,550	
3	$23,030	$57,575	$57,576	$80,605	$80,606	$115,150	
4	$27,750	$69,375	$69,376	$97,125	$97,126	$138,750	
5	$32,470	$81,175	$81,176	$113,645	$113,646	$162,350	
6	$37,190	$92,975	$92,976	$130,165	$130,166	$185,950	
7	$41,910	$104,775	$104,776	$146,685	$146,686	$209,550	
8	$46,630	$116,575	$116,576	$163,205	$163,206	$233,150	
Ea. Addt'l	$4,720	$11,800	$11,801	$16,520	$16,521	$23,600	

**** For families with more than eight members, add $4,720 for each additional member*

If you think you may be eligible, please complete this application and send **with the documentation required from the list on page 3:**

HealthAlliance of the Hudson Valley
Attention: Patient Accounting Dept.
741 Grant Ave, Lake Katrine, NY 12449

A written conditional or final determination of your eligibility will be made within 30 days following receipt of the application. Questions should be directed to 845-334-2743. Once you have submitted this application, please disregard any bills until you receive our response.

DO NOT WRITE BELOW THIS LINE

A. Total Family Annual Income	$
B. Family size of _______	
Eligible Discount Percentage	%

Account#	$ Amount	Discount %	Discount Amount $	Patient Balance$

Total Financial Assistance approved $ ________________________________

_______________________________________ _____________________________________

Approved/Denied by (date) Denial reason

REQUIRED DOCUMENTATION LIST

Proof of Identity (at least ONE from the list below)

- Passport
- Permanent Resident Alien Card (Green Card)
- Birth Certificate for all members in the family including children under 21 years old
- Employment Authorization Card
- Driver License or other State Issued ID
- Photo ID for Spouse / Common-Law Partners

Proof of Address / Residency – Home Address (at least TWO from the list below)

- Utility Bills
- Cell Phone Bills
- Cable Television Bill
- Rent Receipt, Copy of Lease, or Mortgage Papers
- Letter from Person You Reside With or Letter from Landlord (must be notarized)

Proof of Income

- Last Four Weekly Pay Stubs or Two Biweekly Pay Stubs
- Letter from Employer on company letterhead, signed and dated, stating gross income
    - If no letterhead, bring a notarized letter from the employer
- Award Letter from Social Security Administration / Pension / Annuities
- Last Unemployment Benefit Check
- Letter of Support
    - If you are being wholly supported by someone else, bring a notarized letter from that person which states that they are supporting the patient in the absence of income
- If unemployed, explanation of support required
    - Please clarify in a letter how the patient is being supported (i.e. bank savings, etc.)
- Income from Rental of Property, Room, etc.
- If applying for a child, please provide Documentation of Child Support Income
- VA Benefits or Worker's Compensation Income

Other

- Proof of College and or Technical School Attendance.