

For Hospital Use Only:

Patient Name: \_\_\_\_\_

Account #: \_\_\_\_\_

Date Mailed/Given to Pt: \_\_\_\_\_

By Whom: \_\_\_\_\_

Dept: \_\_\_\_\_

### Financial Assistance Application

Nathan Littauer Hospital is committed to providing medical care to those patients who may not have sufficient financial resources to meet their medical care needs. To apply for financial assistance for your hospital account(s), The Financial Assistance Application must be completed, signed and returned to the hospital. Please return all supporting documents with the application. Upon filing a completed application, you may disregard any Nathan Littauer Hospital bills until you receive notification of determination of your application. **APPLICATION AND DOCUMENTATION MUST BE RETURNED TO NATHAN LITTAUER HOSPITAL, 99 E. STATE ST, GLOVERSVILLE, NY 12078 ATTN: PATIENT FINANCIAL SERVICES.**

Upon review of the application, further information may be requested of you. Any potential source of payment, including state and federal assistance programs, all insurance sources, and legal settlements, must be exhausted before forgiveness of account balances will be considered. Your application for assistance will be given equal consideration in a non-discriminatory manner. **Please understand that this application is for consideration of the Hospital charges only and DOES NOT cover billing from your private physician, radiologist, emergency room physician, consulting physician, hospital retail pharmacy or any other services not directly provided by the hospital.**

For questions or to inquire about the status of your application, please call **518-773-5551**.

Patient Name (Last, First, MI)	
Social Security #(Optional)	Date of Birth
Address	Mailing Address (if different from residence)
County of residence _____ Home phone _____	
Employer _____	Phone _____ How long? _____
Previous Employer _____	Phone _____ How long? _____
Spouse's employer _____	Phone _____

### Insurance

If you have medical insurance, please provide that information below. Also, if your hospitalization is the result of an injury or accident, please provide us with the necessary Auto/Homeowner's, Workers Compensation or Third Party insurance below:

Insurance Co. _____	Policy # _____
Address _____	Phone # _____
City/State/Zip _____	Insured _____ SSN#(Optional) _____
Attorney Name/Address/Phone # _____	
Nature of Injury or Accident _____	Police Report # _____

### Household Members and Income Information

Please list all household members and include all sources of income for each household member, including non-employment sources such as Worker's Compensation, Unemployment Compensation, pensions, rental income, interest from investments, dividends, trust funds, child support, alimony, income from Social Security, Veterans Administration or other benefit program.

Family Members	Monthly Gross Income	
Self	\$ _____	Source _____
Husband/Father	SSN(Optional) _____ \$ _____	Source _____
Wife/Mother	SSN(Optional) _____ \$ _____	Source _____
Dependent Children	\$ _____	Source _____
Name _____	Date of Birth _____	
Name _____	Date of Birth _____	
Name _____	Date of Birth _____	
Other Children		
Name _____	Date of Birth _____	Total Monthly Gross Income  \$ _____
Name _____	Date of Birth _____	
Name _____	Date of Birth _____	
<b>Total Family Members</b>		

### Financial Assistance Application

Have you filed for any state or federal assistance during the past year? \_\_\_\_\_ Date of application \_\_\_\_\_

Medicaid    Y    N            Social Security Disability    Y    N            Victims Compensation    Y    N

Please list any recent accounts that you or your immediate family members may have at Nathan Littauer Hospital or one of our Primary Care Sites.

Patient Name

Account #

Date of Service

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that the above information is true and accurate to the best of my Knowledge. I have read and agree to comply with all terms and requirements set forth in the notice of availability of financial assistance.

Signature of applicant: \_\_\_\_\_

Date: \_\_\_\_\_

For Hospital Use Only:    ☐ Referred to DSS    ☐ SSI    ☐ Victim's Comp    ☐ Other: \_\_\_\_\_

Account Number

Reviewed

Approved

Denied

_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

## 2018 Financial Assistance Income Guidelines

Family Size	Annual Income					Discount Amount %
	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL	
1	\$ 12,140.00	\$ 18,210.00	\$ 24,280.00	\$ 30,350.00	\$ 36,420.00	Over
2	\$ 16,460.00	\$ 24,690.00	\$ 32,920.00	\$ 41,150.00	\$ 49,380.00	Over
3	\$ 20,780.00	\$ 31,170.00	\$ 41,560.00	\$ 51,950.00	\$ 62,340.00	Over
4	\$ 25,100.00	\$ 37,650.00	\$ 50,200.00	\$ 62,750.00	\$ 75,300.00	Over
5	\$ 29,420.00	\$ 44,130.00	\$ 58,840.00	\$ 73,550.00	\$ 88,260.00	Over
6	\$ 33,740.00	\$ 50,610.00	\$ 67,480.00	\$ 84,350.00	\$ 101,220.00	Over
7	\$ 38,060.00	\$ 57,090.00	\$ 76,120.00	\$ 95,150.00	\$ 114,180.00	Over
8	\$ 42,380.00	\$ 63,570.00	\$ 84,760.00	\$ 105,950.00	\$ 127,140.00	Over
	100%	80%	60%	40%	20%	0

\* For family units of more than 8 members, add \$4,320 for each additional member.