



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 _____	\$ _____
Total Family Members _____		

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
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2019 Financial Assistance Income Guidelines

Family Size	Annual Income					Discount Amount %
	100% FPL	150% FPL	200% FPL	250% FPL	300% FPL	
1	\$ 12,490.00	\$ 18,735.00	\$ 24,980.00	\$ 31,225.00	\$ 37,470.00	Over
2	\$ 16,910.00	\$ 25,365.00	\$ 33,820.00	\$ 42,275.00	\$ 50,730.00	Over
3	\$ 21,330.00	\$ 31,995.00	\$ 42,660.00	\$ 53,325.00	\$ 63,990.00	Over
4	\$ 25,750.00	\$ 38,625.00	\$ 51,500.00	\$ 64,375.00	\$ 77,250.00	Over
5	\$ 30,170.00	\$ 45,255.00	\$ 60,340.00	\$ 75,425.00	\$ 90,510.00	Over
6	\$ 34,590.00	\$ 51,885.00	\$ 69,180.00	\$ 86,475.00	\$ 103,770.00	Over
7	\$ 39,010.00	\$ 58,515.00	\$ 78,020.00	\$ 97,525.00	\$ 117,030.00	Over
8	\$ 43,430.00	\$ 65,145.00	\$ 86,860.00	\$ 108,575.00	\$ 130,290.00	Over
	100%	80%	60%	40%	20%	0

* For family units of more than 8 members, add \$4,420 for each additional member.