# FINANCIAL ASSISTANCE PROGRAM

*I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance which may be available for payment of my facility charges, if requested, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the facility the amount recovered for facility charges. If any information I have supplied proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action is deemed appropriate.*

Applicant's Signature

PLEASE PROVIDE US WITH THE FOLLOWING:

1. Proof of individual (if single) or family income. if married. We require pay stubs showing year-to-date earnings.
2. Previous year's tax return.
3. Current checking and savings account statements.
5. Current stock, bond, and CD statements.
6. Please explain why the bill is a hardship:

If you require any assistance in filling out this application please contact one of our Financial Counselors at:

**518-583-8343**

# FINANCIAL ASSISTANCE PROGRAM

Please return the completed application to:

**Patient Financial Services**
**PO Box 5178**
**Saratoga Springs, NY 12866**

For questions please call:

**518-583-8343**

To review our program guidelines visit our website at:

**WWW.SARATOGAHOSPITAL.ORG**

MALTA MED EMERGENT CARE

February 2013

APPLICATION FOR

# FINANCIAL ASSISTANCE PROGRAM

FINANCIAL ASSISTANCE FOR
CARE RECEIVED AT
MALTA MED EMERGENT CARE

MALTA MED EMERGENT CARE

# GENERAL PROGRAM G

1. The facility uses a sliding scale for Financial Assistance Program sponsorship based on annual income for all family members, residing in the same residence, and other asset such as checking and savings accounts and other liquid assets up to four times the Federal Poverty Guidelines.
2. Approval for sponsorship for of all or partial amounts of your bill is limited to one year.
3. Previous accounts which are involved in litigation are not eligible under the program. The hospital will consider accounts created within six months of the date of the application.
4. The program only covers amounts billed by Malta Med Emergent Care. Physician services rendered at these locations are not covered under the program.
5. The program only covers those services that are medically necessary. Cosmetic services are not covered.
6. Eligibility of a minor or a child over 18 who is living at home will be determined by including the parent's income and assets.

## GENERAL APPLICANT GUIDELINES

Applicants must comply with all the requirements below. Intentional misrepresentation of the facts will result in the denial of this and all future applications. This program is designed to help alleviate the financial burden of medical care but not to replace the Medicaid program.

Please return this application to:
**Patient Financial Services**
**PO Box 5178**
**Saratoga Springs, NY 12866**

# UIDELINES

## TO BE ELIGIBLE FOR THE FINANCIAL ASSISTANCE PROGRAM THE APPLICANT MUST AGREE TO:

1. Abide by the sliding scale the facility uses that is based on an annual income for all family members residing in the same location utilizing other liquid assets such as, but not limited to, checking and savings accounts up to four times the Federal Poverty Income Guidelines.
2. Apply for Subsidized Insurance Programs, if qualified, and provide the hospital with copies of any Medicaid denials. Any Medicaid denial because of untimely application, transfer of assets, or non-disclosure of financial information will eliminate the applicant from consideration of coverage under this program.
3. Provide proof of individual income (if single) or family income in the form of the previous years signed tax return or other items as required by the hospital such as checking and savings account statements. In the event the applicant has not, or does not file a tax return, copies of the last two months pay stubs accompanied by a signed statement acknowledging the lack of a tax return would be sufficient.
4. The percentage of discount for a partial write-off may only be determined after all sources of payment have been applied.
5. The application must be in writing.
6. If you apply for this program and are denied you may appeal this decision by contacting:

**Director of Patient Financial Services**
**Saratoga Hospital**
**211 Church Street**
**Saratoga Springs, NY 12866**

*Requests for Appeal must be in writing and should contain specific reasons why you disagree with the decision.*

# MALTA MED EMERGENT CARE
# FINANCIAL ASSISTANCE PROGRAM

Date _____

Patient name _____
(last) (first)

Address _____

Phone # ( _____ ) _____

Soc. Sec. # _____

Patient or guarantor occupation _____

_____

Soc. Sec. # _____

Patient or guarantor employer _____

_____

_____

Family size (list all names) _____

_____

_____

## FAMILY INCOME

**Entire family unit wages:**

Patient _____

Spouse _____

Children _____

Other _____

Social security _____

Pension _____

Unemployment _____

Worker's Compensation _____

Child Support _____

Value of:

- Stocks _____
- Bonds _____
- CDs _____
- Savings account _____
- Checking account _____