

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



SARATOGA HOSPITAL

people you trust. care you deserve.

Revised 3/2013

APPLICATION FOR

FINANCIAL
ASSISTANCE
PROGRAM

FINANCIAL ASSISTANCE FOR
CARE RECEIVED AT
SARATOGA HOSPITAL
AND AFFILIATES



SARATOGA HOSPITAL

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GENERAL PROGRAM GUIDELINES

1. The hospital 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 Saratoga Hospital and its affiliates. 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 and Nursing Home 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

GUIDELINES

TO BE ELIGIBLE FOR THE COMMUNITY CARE PROGRAM THE APPLICANT MUST AGREE TO:

1. Abide by the sliding scale the hospital 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.

SARATOGA HOSPITAL 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 _____