



Alice Hyde Medical Center

Identification Number	LD - 10
Type of Policy	Administrative
Applicability	All Departments
Owner's Dept	Finance
Title of Owner	SVP Finance
Title of Approving Official	President
Date Created	12/1990
Date Released	9/2022
Next Review Date	9/2024

SUBJECT: PATIENT FINANCIAL ASSISTANCE POLICY

PURPOSE: To establish a policy and procedure for the administration of The University of Vermont Health Network - Alice Hyde Medical Center's Patient Financial Assistance Program.

POLICY: The University of Vermont Health Network - Alice Hyde Medical Center (UVMHN-AHMC) is a patient centered organization committed to treating all patients equitably, with dignity and respect regardless of the patient's healthcare coverage or financial resources. Further, UVMHN - AHMC is committed to providing financial assistance to persons who have essential healthcare needs and are uninsured, underinsured, or otherwise unable to pay for medically necessary care based on their individual financial situation. Consistent with our mission to deliver compassionate, high quality, affordable healthcare services and to fulfill our obligation as a non-profit organization, UVMHN - Alice Hyde Medical Center strives to ensure that the financial capacity of people requiring healthcare services does not prevent them from seeking or receiving care at our facility.

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with UVMHN - AHMC's procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services for their overall personal health.

No patient will be denied medically necessary services based upon ability to pay. Discounts are based on family size and income. Applicants are not required to enroll in public health programs or provide proof of Medicaid denial as a condition of applying for the Financial Assistance Program.

To manage our resources responsibly and to allow UVMHN - AHMC to provide the appropriate level of assistance to the greatest number of persons in need, the following procedures have been established for the provision of patient financial assistance.

PROCEDURE:

Healthcare Service Eligibility:

The following services are eligible for financial assistance

- Emergency medical services provided in emergency room setting
- Urgent services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the individual

- Non-elective services provided in response to life threatening circumstances in a non-emergency room setting, and
- Elective medically necessary services for patients who meet established program guidelines

Services not eligible for financial assistance:

- Cosmetic services unless medically necessary based upon physician review
- Infertility/fertility services, e.g. birth control, vasectomies/reversals, tubal ligations/reversals, unless medical necessity documentation from physician is provided
- General dentistry unless medically necessary extenuating circumstances are presented by the dental program
- Non-emergent foreign national including obstetrics and labor and delivery
- Services deemed not medically necessary
- Services reimbursed directly to the patient by an insurance carrier or third party
- Skilled nursing facility care provided at the Alice Center
- ALP services provided at the Alice Center
- Availability of FAP program will be made available to all patients at time of service, on our website, and on patient statements.

Provider Coverage

All UVMHN - AHMC employed medical providers rendering care at our facility are covered under this policy. For a listing of providers rendering care at the UVMHN - AHMC and an indication as to whether their services are covered under this policy see our website at <http://www.alicehyde.com/Patients-Visitors>.

Patient Eligibility

Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, and who are unable to pay for their care, based upon a determination of financial need in accordance with this policy. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, color, sex, sexual orientation, gender identity or expression, ancestry, place of birth, HIV status, religion, marital status, immigrant status, language, socioeconomic status, physical or mental disability, protected veteran status or obligation for service in the armed forces. Discounts are based on income and family size only.

Income Test: Patients whose household income is at or below 400% of the Federal Poverty Level Guidelines (FPLG), as adjusted for household size, pass the income test and are considered for charity care assistance.

Non-custodial parents may have their income adjusted for child support when supporting documentation of payment is provided.

Patients may have their income adjusted for alimony when supporting documentation of payment is provided.

Students between the ages of 18-21 may be included within the household when more than 50% of the support is provided by the parent/applicant. To qualify for this household extension, the student must be listed as a dependent on the Federal Income Tax return.

Residency Criteria

Patients must reside within the service area, unless medical services were urgent or emergent in nature. Eligibility for patients residing outside of service area will be determined on a case by case basis. Financial assistance for residents outside may be granted only in unique circumstances and with appropriate approval.

Residents of the service area, including college students who reside in the service area part-time, must live in our service area greater than 6 months per annum to meet the residency requirement.

Proof of residency may be established by the following:

- Service area's driver's license, tax bill with service area address, lease for service area property or a service area utility bill;
- Potential exceptions may be considered on individual case by case basis

Health Insurance and Liability Payments

Services rendered at UVMHN - AHMC will be billed to patients' primary coverage, a private medical insurance, an employer occupational health plan, workers' compensation, or pending by medical pay/third party liability carriers. In cases where there is a potential auto/injury liability payment pending at a future date, UVMHN - AHMC may file a lien to protect its financial interests, excluding Medicare/Medicaid recipients. After lien is filed, financial assistance may be granted assuming that the patient otherwise qualifies. If there is a future time when liability payments are distributed, the UVMHN - AHMC lien will allow UVMHN - AHMC to recover some or all of the financial assistance initially granted to the patient.

Public Healthcare Program/Healthcare Exchange Criterion

Patients applying for financial assistance are reviewed for their potential eligibility for state or federal healthcare program benefits and/or benefits offered through the NY Healthcare Exchange programs. Any patient identified with potential to be granted such assistance will be instructed to apply. For those patients identified as candidates for eligibility for the NY Healthcare Exchange Program, application for and compliance with those program guidelines is a prerequisite for financial assistance.

Exclusions: A patient who's religious or cultural belief system prohibits seeking or receiving financial assistance from a government entity may be excluded from the public healthcare program criterion. The patient will, however, be required to assume a portion of financial responsibility to be assessed by the Financial Assistance Program manager.

Determination of Financial Need:

Financial need will be determined in accordance with procedures that involve an individual assessment of financial need which may include the following: (Note, in the case of presumptive charity, the application process may be excluded).

- An application process, in which the patient or patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
- Include the use of external publicly available data sources that provide information on a patient's or patient's guarantor's ability to pay. UVMHN - AHMC reserves the right to obtain a credit report, when approval from the patient is granted, to verify financial stability before financial assistance is authorized;
- Include reasonable efforts by UVMHN - AHMC to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist and/or refer patients to apply for such programs;

- Include a review of the patient's UVMHN - AHMC outstanding accounts receivable for prior services rendered and the patient's payment history

It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. A patient must have either a current patient balance that is due to UVMHN - AHMC, an expectation that an account currently pending insurance will leave a balance due, or a future scheduled service at UVMHN - AHMC that is expected to leave a patient balance. However the determination may be done at any point in the billing cycle.

The University of Vermont Health Network - AHMC's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for charity shall be processed promptly and UVMHN - AHMC shall notify the patient /applicant of decision in writing within 30 days of receipt of a completed application.

Financial Assistance Eligibility Period

The need for charity assistance shall be reevaluated at each subsequent time of service if the last financial evaluation was completed more than six months prior, or at any time additional information relevant to the eligibility of the patient for charity becomes known. Reevaluation of patients whose age exceeds 65 and whose income is fixed below 400% FPLG shall occur annually. Note: It is permissible for patients to submit new supporting financial documentation provided the application on file is less than one year old.

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance application on file due to lack of supporting documentation. Often there is adequate information provided by the patient or through other sources that could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UVMHN - AHMC may use outside agencies in determining estimated income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance.

Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Eligibility for other state or local assistance programs that are unfunded (e.g. Medicaid spend down)
- Food stamp eligibility
- Participation in Women, Infants and Children Programs (WIC)
- Transient
- Patient is deceased with no known estate (documented by probate court)
- Patient is incarcerated with no health care coverage

Patient Financial Assistance Guidelines

In accordance with financial need, eligible services under this policy will receive financial assistance based upon the federal poverty guidelines. The amount of assistance provided to a patient will vary based upon their income level and the grant awarded shall ensure the patient is not responsible for more than the Amount Generally Billed (AGB) to an insured patient and the Maximum Amount Paid (MAP) by the Highest Volume Payor (HVP), (see definitions for AGB, MAP, HVP).

As defined by the IRS, eligible patients cannot be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance coverage. The amounts generally billed (AGB) to patients is calculated by UVMHN - AHMC using the "Look-Back method" of:

Actual claims paid to the organization by Medicare together with all private health insurers including any associated portions of those claims paid or owed by beneficiaries. Additionally, as provided for in NYS PHL 2807, eligible patients cannot be charged more for emergency or other medically necessary care than the Maximum Amount Paid (MAP) by the Highest Volume Payor (HVP). This forms the minimum grant percentage awarded to patients who qualify for assistance. Calculation: Allowed claims/Charges for prior fiscal year.

These calculations for the previous fiscal year shall determine the grant percentage to be applied to the 351%-400% FPL level. Additional discounts shall apply to each FPLG category up to a maximum assistance grant of 100% for <200% FPLG.

FPLG	Less than 200%	201% - 250%	251% - 300%	301% - 350%	351% - 400%
Financial Assistance Percentage	100%	85%	75%	65%	55%

The patient grant is applied against all current balances (i.e. hospital and medical group) and extends for a coverage window of 6 months, 12 months for aged > 65 years on a fixed income. When the grant period has closed, patients will be required to re-apply for financial assistance and based upon their financial status, may have their grant category adjusted.

Safe Harbor

UVMHN - AHMC shall limit all charges for financial assistance qualified individuals to the amounts generally billed to insured patients. The hospital will refund any amount paid in excess of the amount he or she is personally responsible for paying under the financial assistance policy with the application period or 240 days prior to the receipt of a completed application. Payments made outside the application period will not be eligible for a refund.

Catastrophic Medical Indigence

UVMHN - AHMC has determined that catastrophic assistance beyond 400% of the FPLG will be reviewed for an appropriate level of financial assistance. Medically indigent in most cases will be a patient for whom the balance exceeds 30% of the person’s annual household gross income and who is unable to pay all or a portion of the bill balance resulting from catastrophic illness or injury. Cases that are deemed Medically Indigent will be processed at the 100% FPLG grant percentage level of assistance and will be applied against all current balances (hospital and medical group). Patients who qualify for catastrophic medical indigence will have their out of pocket liabilities capped at no more than \$10,000.

Individual Case Reviews and Appeals Process

UVMHN - AHMC acknowledges that extenuating circumstances may exist where an individual’s income exceeds program eligibility guidelines. The program administrator, on an as-needed basis, will review unusual or catastrophic cases that do not meet established program guidelines but present unusual hardship.

Other cases involving services that require review for medical necessity will be presented to the Chief Medical Officer or his/her designee for a decision regarding medical necessity of services rendered. If services are deemed medically necessary and the charity eligibility guidelines are met, assistance will be granted.

Patients whose applications for charity are denied may appeal the final decision. Requests for appeal should be sent to the Patient Financial Services Department Director, in writing, within 30 days of receipt of the denial and must clearly indicate the reason for the appeal, with supporting documentation. All cases will be reviewed by the Director of Revenue Cycle. The patient will be notified of the final grant/deny decision.

Notification Period

UVMHN - AHMC will make reasonable efforts to notify patients about the financial assistance program. This period begins on the date a billing statement for the patient balance of care is presented and ends 120 days later. As defined in this policy, multiple methods of notification occur beginning in advance of care, during care and throughout the 120 day billing cycle.

Application Period

UVMHN - AHMC will process applications submitted by individuals during the application period which begins on the date a billing statement for the patient balance of care is presented and ends 240 days later. If at the end of the 120 day notification period an account has been referred to a collection agency and an application has been received and granted within the 240 day application period, accounts shall be recalled from the agency and processed under the financial assistance program.

Reasonable Efforts

Reasonable efforts will be made to determine if a patient is eligible for financial assistance prior to balance transfer to collections. Reasonable efforts may include the use of presumptive scoring, the notification and processing of applications and notification before, during and after care.

- UVMHN - AHMC shall not initiate any ECA (extraordinary collection actions)
- Incomplete applications shall be processed with notification to patients providing direction on how to appropriately complete the application and/or what additional documentation is required along with a 30 day window of time to respond to UVMHN - AHMC.
- UVMHN - AHMC shall process completed applications within 30 days of receipt.

University of Vermont Health Network Partners

As stated previously the average generally billed and the federal poverty level coverage for each network affiliate varies; UVMHN partners have agreed to share FPL information to help expedite the financial review for our shared patients. For patients who receive care at a network affiliate a single application with supporting documentation may be submitted for financial assistance. This does not guarantee a grant at each organization nor does it guarantee the grant awarded at one organization will be awarded at a network affiliate. If an application is approved and the patient indicates balances at another network hospital exists, the patient's FPL will be shared with the affiliate. The affiliate will then determine whether the patient qualifies for assistance at their facility and if so, the amount of the awarded grant, if any. Applications will be shared with partner affiliates for review upon request; applications and supporting documentation will be made available to partner organizations as needed to facilitate audit functions.

Communication of the Charity Program to Patients and the Public

Notification about financial assistance is available from the UVMHN - AHMC, which shall include a contact number, shall be disseminated by UVMHN - AHMC by various means, which may include, but are not limited to:

- Reference to the charity program is printed on each statement
- Posting notices in emergency rooms, admitting and registration departments, and the Patient Financial Service office, and other conspicuous displays located throughout points of entry.

- By providing a copy of the plain language policy summary at the point of registration on the facility campus and making available the summary at our satellite locations. Providing copies of the policy and application upon request.
- Information shall be available on the UVMHN - AHMC website, including the policy, a plain language summary, the application, FAQ, FPLG guidelines and contact information for assistance.
- Referral of patients for charity assistance may be made by any member of the UVMHN - AHMC staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains and religious sponsors. A request for charity may be made by the patient, or family member, close friend or associate of the patient, subject to applicable privacy laws.
- Translations for individuals with limited English proficiency will be provided for populations with > 1,000 individuals or 5% of the service area community based upon US Census Bureau statistics.
- Patients requiring a translated copy and/or assistance in completing the application will be assisted by financial advocates and/or UVMHN - AHMC staff who will secure the services of an appropriate interpreter.
- Information, rack cards and flyers are available through the Community Wellness department, where staff routinely interacts with community centers and advocates disseminating information and programs available to the public.

Application Assistance Contact Information

Assistance in completing the application may be obtained through the Patient Financial Services Office located at 133 Park Street. Information regarding our policy and/or application may be obtained by contacting the Patient Financial Services department at 1-518-481-2241 or in person at The University of Vermont Health Network – Alice Hyde Medical Center Business Office at 133 Park St., Malone NY.

Relationship to Collection Policies

Management shall develop policies and procedures for internal and external collection practices that take into account the extent to which the patient qualifies for charity, a patient’s good faith effort to apply for charity from the UVMHN - AHMC, and a patient’s good faith effort to comply with his/her payment agreements with UVMHN - AHMC. For patients who qualify for charity and who are cooperating in good faith to resolve their hospital bills, the UVMHN - AHMC may offer extended payment plans to eligible patients.

Note: UVMHN - AHMC will not engage in extraordinary collection actions (ECA). ECA is defined as selling an individual’s debt to another party, reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus, deferring, denying or requiring payment before providing medically necessary care because of an individual’s non-payment of one or more bills for previously provided care under the FAP and/or actions requiring a legal or judicial process.

FAP Adjustment Authority Levels

The following approval levels will be followed before charges may be adjusted off an individual’s patient account under the Financial Assistance Program:

\$1 - \$20,000	PFS Representative
\$20,001 - \$100,000	Director Revenue Cycle
\$100,001 +	CFO/VP Finance

Procedure Review

The sliding fee schedule will be updated based on Federal Poverty Guidelines.

Regulatory Requirements

In implementing this policy the UVMHN - AHMC management and facilities shall comply with all other federal, state, and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.

Document Retention

Completed applications for the Patient Assistance Program will be maintained for a period of ten years after the date the application was approved or denied.

Monitoring Plan

Compliance with this policy will be monitored through annual review of the Financial Assistance Program applications and grant/deny decisions.

Definitions:

For the purpose of this policy the terms below are defined as follows:

- **AGB:** Amount generally billed to insurance payors for services provided. The look-back method is used to calculate the AGB, reflecting a combination of fully adjudicated claims for Medicare fee for service and all private health care plans, including the portions paid or owed by beneficiaries.
- **HVP:** Per NYS PHL 2807, the “highest volume payor” shall mean the “insurer, corporation or organization licensed, organized or certified pursuant to Article 32, 42 or 42 of the insurance law or article 44 of this chapter, or other third party payor, which has a contract or agreement to pay claims for services provided by the general hospital and incurred the highest volume of claims in the previous calendar year.”
- **MAP:** Maximum Amount Paid per NYS PHL 2807 is the greater of the amount that would have been paid for the same services by the highest column payor for such general hospital, or for services provided pursuant to Title XVIII of the federal social security act (Medicare) or for services provided pursuant to Title XIX of the federal social security act (Medicaid) and provided further that such amounts shall be adjusted according to income level.
- **Charity:** refers to healthcare services provided without charge or at a sliding scale discount to qualifying patients
- **Family:** A group of two or more people (one whom is house-holder) related by birth, marriage, or adoption and residing together; all such people are considered members of one family. AHMC will also accept non-related household members when calculating family size.
- **Family Income:** Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:
 - Includes earnings, unemployment compensation, workers compensation, Social Security, Supplemental Security Income, public assistance, veterans’ payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estate, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.

- Noncash benefits (such as food stamps and housing subsidies) do not count
 - Determined on a before tax basis
 - Excludes capital gains or losses
 - If a person lives with a family, includes the income of all family members (non-relatives such as housemates do not count)
- **Foreign National:** Non US citizens who are in the United States under a travel/visitor visa
 - **The UVMHN - AHMC Service area:** New York (Clinton, Essex, Franklin, Washington, Hamilton, Warren and St. Lawrence)
 - **FSC Financial Status Class** of a patient account, indicates primary payor responsible for payment
 - **LEP/Translation:** Limited English proficiency requiring translated copies of the policies, application, plain language summary and application.
 - **Medical Indigence:** There are instances when individuals are financially unable to access adequate medical care without depriving themselves and their dependents of food, clothing, shelter and other essentials of living. A patient will generally be considered Medically Indigent if the balance of a hospital bill exceeds 30% of the person's annual household gross income and he or she is otherwise unable to pay all or a portion of the bill balance resulting from a catastrophic illness or injury.
 - **Medical Necessity:** Services or items that are: (1) appropriate for the symptoms or diagnosis or treatment of the condition, illness, disease or injury; (2) provided for the diagnosis or the direct care of the condition, illness, disease or injury; (3) in accordance with current standards of good medical practice; (4) not primarily for the convenience of the patient or provider; and (5) the most appropriate supply or level of service that can be safely provided to the patient.
 - **Patient Statement:** The monthly patient account summary mailed to a patient at their stated home address which states the amount due from the patient for patient care services rendered by UVMHN - AHMC.
 - **Primary Homestead:** The primary residence of the patient, whether solely or jointly owned.
 - **Uninsured:** The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations. An uninsured patient is ineligible for any government healthcare entitlement program (Medicare, Medicaid, etc) during the dates of service provided by UVMHN - AHMC.
 - **Underinsured:** The patient has some level of insurance or third party assistance but still has out of pocket expenses that exceed his/her financial abilities.
 - **Uninsured Self Pay FSC:** The financial status class (FSC) for those patients who have no third party health care insurance benefits, and are directly responsible for payment of their healthcare services.
 - **UVMHN - AHMC:** The University of Vermont Health Network – Alice Hyde Medical Center
 - **University of Vermont Health Network:** Includes the University of Vermont Medical Center, Central Vermont Medical Center, Champlain Valley Physicians Hospital, Elizabethtown Community Hospital and Alice Hyde Medical Center.

DISTRIBUTION

This policy is available on the portal for all employees on an as needed basis.
All questions regarding this policy or its implementation must be referred to your immediate supervisor.

MONITORING PLAN: Biennially

REFERENCES: IRC Section 501(r), NYS PHL 2807 – k (9-a), NYS DOH HFAL

REVIEWERS: Director Revenue Cycle, AVP Finance, SVP Finance/CFO

BOARD APPROVAL: YES

Financial Assistance Program Application
The University of Vermont Health Network - Alice Hyde Medical Center
199 Park Street, Malone, New York 12953
(518) 481-2241

Dear Applicant,

Thank you for choosing Alice Hyde Medical Center as your health care provider.

If payment of your medical bills creates a financial hardship for you, you may be eligible for financial assistance through Alice Hyde Medical Center's Financial Assistance Program. Our staff is here to help you and is willing to work through the process with you. Please note that before any financial assistance can be provided by Alice Hyde Medical Center, our staff will work with you to identify other sources of payment.

The following criteria must be met to be eligible for financial assistance from Alice Hyde Medical Center:

- You must be a permanent resident within the Alice Hyde Medical Center service area. If you live outside the service area you are not eligible for Alice Hyde Medical Center assistance unless your services were documented as urgent or were provided on an emergency basis.
- The services that were provided to you must be considered medically necessary essential health care services.
- The following types of services are not considered medically necessary and/or excluded from the program:
 - Cosmetic services - unless medically necessary based upon diagnosis with physician review.
 - Birth control, infertility treatments, fertility services, sterilization and reversal of sterilization.
 - Services that have been placed in Collections beyond 120 days of placement.
 - Services reimbursed directly to you by your insurance carrier or already covered by another third party.
 - General Dentistry.
- Household income must be within income guidelines (see last page).

If you meet the criteria and wish to apply for the Alice Hyde Medical Center Financial Assistance Program, please complete the enclosed application form. Please note, you will continue to be financially responsible for all services you receive until it is determined if you qualify for assistance.

We are here to help. If you have any questions or require aid in understanding any part of the application process, please contact our Patient Financial Services office at (518) 481-2241. Completed applications should be forwarded to the following address:

The University of Vermont health Network- Alice Hyde Medical Center
Patient Financial Services
199 Park Street
Malone, New York 12953

Financial Assistance Program Application

For your Convenience - Our Documentation Check List

To determine if you qualify for assistance, you will need to show proof of your income, and also supply documentation necessary for determination. Please fill out the attached application in full, sign it, and send the application along with a copy of each of the following documentation that is applicable for your household:

Note: If sending bank statement or online documentation, copies must include bank name, client name, balance and current date.

- Optional: Complete copy of your most recent Federal Income Tax Return and all schedules and forms (e.g. 1040, 1040A, 1040 EZ, 1099 etc.)
- Self employed/Sole Proprietor must provide complete documentation of the following:
 - a. Optional: Federal Tax Returns and year to date profit and loss statement
 - b. Optional: Partnership: All of the above, plus Partnership Federal Tax Return
 - c. Optional: Corporation: All of the above, plus Corporation Federal Tax Return
- Copies of the two (2) most recent, consecutive paycheck stubs or a statement from the employer.
- Copy of one (1) most recent bank statement (e.g. checking, savings, etc.)
- Copy of unemployment benefits statement if applicable (e.g. check, bank statement, online, etc.)
- Copy of disability compensation benefit statement/award letter (e.g. check, bank statement, etc.)
- Copy of social security, pension, retirement income (e.g. award letter, check stub, bank statement, etc.)
- Documentation of child support and/or alimony paid or received (e.g. cancelled check, garnishment, bank statement, etc.).
- Rental Income - Copy of current Schedule E of IRS form.
- If an application for state assistance (e.g. Medicaid, State Health Exchange) has been made in the last 60 days, please provide a copy of application.
- If proof of residency is required, please send one of the following: NY driver's license, property tax bill, lease of property or a utility bill.
- Other: _____

Please use the above checklist to be sure we have all your information we need to quickly and accurately process your application. It is important that your application be complete and that all necessary documentation is received. All information you provided is confidential.

Questions & Answers and Information You Should Know...

Can I get help completing my application?

Yes. Please contact Patient Financial Service at (518) 481-2241 with questions. If you would like to speak to a representative in person our Patient Financial Services Office is located at 199 Park Street, Malone, New York 12953.

If a question or section does not pertain to me, can it be left blank?

No. We cannot assume an unanswered question or section means it does not apply to you. One of the requirements when applying for financial assistance with Alice Hyde Medical Center is a complete application. If a section or question does not apply, write "N/A" for not applicable.

I don't have all the documentation requested but the application is due back. Can I send what I have?

No. You must return a complete application with all the appropriate documentation applicable or the application will be returned as denied. Extension will only be made on a case by case basis for extenuating circumstances and must be requested by contacting Customer Service or the Financial Program Specialist at (518) 481-2241.

Why was the verification I sent for my bank account(s) not accepted?

We require a copy of the original bank statement(s). If this is not available we will only accept a substitute statement which has the following: bank name, client name, type of account, current date and current balance. Each of these items must be printed on bank letterhead and not hand written.

What is the benefit award letter?

If you are receiving social security or disability benefits, this is yearly letter that social security sends notifying you of your monthly eligible benefits. For verification purposes we will accept a copy of the benefit award letter, a copy of your social security (disability) check or if you have direct deposit we will accept your bank statement showing your social security deposit as verification. Whichever verification is used, the monthly eligibility benefits should match the amount given on the application.

My employer does not provide pay stubs, what should I do?

If pay stubs are not provided by your employer, an affidavit on letterhead from the company you work for will be accepted. The affidavit must show gross pay, deductions, and net pay for one month. Please note, if you are married or have a civil union partner, his/her verification is also required.

Questions & Answers and Information You Should Know continued...

What is the coverage period for Financial Assistance?

Financial assistance is valid for up to Six (6) months and may include coverage to current balances unless otherwise noted. Your coverage period will be indicated on your grant letter. If your income indicates you may be eligible for Medicaid, NY Essential health Plan or another insurance program funded by state, you will only be granted financial assistance for current charges until a Medicaid application is made and received by the Financial Assistance Department.

How often do I need to re-apply for financial assistance?

The Financial Assistance Program at Alice Hyde Medical Center is not an insurance company or a program such as Medicaid, or NY Essential Health Plan. We are here to assist patients who face financial hardship and are unable to pay their bills. Financial assistance should only be applied for if you have outstanding Alice Hyde Medical Center medical bills you cannot pay, expectation that an account currently pending insurance will leave a balance, or expectation that a future scheduled service will leave you a balance.

Financial Assistance Application

Applicant's Information

Last Name	First Name	Middle Initial	Social Security Number (optional)	Date of Birth
Address	City	State	Zip Code	Home Phone #
Medical Record #				
Employer	Or choose from the following options:		<input type="checkbox"/> Student	<input type="checkbox"/> Unemployed
			<input type="checkbox"/> Disabled	<input type="checkbox"/> Retired
Marital Status – please choose from the following options:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced
	<input type="checkbox"/> Widowed			
Spouse Last Name	Spouse First Name	Middle Initial	Social Security Number (optional)	Date of Birth
Spouse Employer	Or choose from the following options:		<input type="checkbox"/> Student	<input type="checkbox"/> Unemployed
			<input type="checkbox"/> Disabled	<input type="checkbox"/> Retired

Household Information

- Please list all dependents who live in your household below
 - It is not necessary to include non-dependents who reside in your household
- Note:** You may include dependent students (21 and under) for which you provide at least 50% support and who are reflected as dependents on your Federal Income Tax Returns.

Last Name	First Name	Social Security # (optional)	Relation to Applicant	Date of Birth

Monthly Household Expenses

This information is not required but may be useful in making a determination

Mortgage Rent Amount \$ _____ Property tax amount NOT included in Mortgage/Rent \$ _____

Do you own property other than primary residence? Yes No If yes, monthly loan payment: \$ _____

Utilities	\$ _____	Credit Card	\$ _____	Insurance (auto, life, property)	\$ _____
Auto	\$ _____	Health Insurance	\$ _____	Alimony/Child Supp.	\$ _____
Child Care	\$ _____	Healthcare Bills	\$ _____	Other:	\$ _____
Living (gas, food, etc.)	\$ _____	Medications	\$ _____	Other:	\$ _____

Additional Information

Are you covered under any health insurance policy? Yes No
 If yes, list insurance(s): _____

Are you seeking Financial Assistance for services resulting from any of the following? Yes No
 Work Related Liability Motor Vehicle

Do you have an application pending for insurance on the Health Exchange or State Aid such as Medicaid, or NY Essential Health Plan? Yes No

Did you file and/or are you required to file a Federal Tax Return? Yes No
 You may wish to provide copies of your current Federal Income Tax Return (optional)
 If No, why? _____

Do you reside in New York greater than 6 months per year? Yes No

Income

MONTHLY INCOME FROM:

Person 1

Person 2

Name of household member: _____

Documentation required for verification
**Optional

Gross Salary Wages	\$	\$	2 consecutive pay stubs/empl. pay stmt
Self Employed	\$	\$	**Tax return plus current YTD profit/Loss
Social Security	\$	\$	Award letter, check stub, bank stmt
Worker's Compensation	\$	\$	Check, bank stmt, online, etc.
Unemployment	\$	\$	Check, bank stmt, online, etc.
Alimony/Child Support	\$	\$	Cancelled check, garnishment, bank stmt.
Pension/Retirement Income	\$	\$	Bank stmt or Pension check stub
Disability	\$	\$	Check, bank stmt, online, etc.
Rental Income	\$	\$	Schedule E of IRS tax form
Dividend Income	\$	\$	Current/Quart. stmt from fin. institution
Other Income	\$	\$	Contact FAP Specialist
Total:	\$	\$	
Cash, Savings & Investments			
Checking Acct. Balance	\$	\$	Bank Statement
Savings Account	\$	\$	Bank Statement
CD Account Balances	\$	\$	Copy of Statement
Bonds	\$	\$	Copy of Statement or Bond
Annuities	\$	\$	Copy of Statement
Money Market	\$	\$	Copy of Statement
Trust Account	\$	\$	Copy of Statement
Stocks	\$	\$	Copy of Statement
Mutual Funds	\$	\$	Copy of Statement
Other:	\$	\$	Contact FAP Specialist
Total:	\$	\$	

Acknowledgement – Please Read Carefully

I am requesting Financial Assistance from The University of Vermont Health Network – Alice Hyde Medical Center. I verify that all information I have provided is accurate and complete. The University of Vermont Health Network – Alice Hyde Medical Center has my permission to pursue verification of pertinent information and any incorrect, incomplete or false information provided may cancel my application for Financial Assistance. I agree to repay the full Financial Assistance award if I receive payment of any kind for the medical services covered by this Financial Assistance application. The University of Vermont Health Network – Alice Hyde Medical Center is authorized to access credit bureau files and reports, now and in the future for collection purposes. All information provided will remain confidential under the provisions of HIPPA federal regulations.

Signature of Patient (Parent/Guardian if Patient is under 18)

Date