CMH
Columbia Memorial Health

To Whom It May Concern,

Columbia Memorial Hospital, as a community service, may provide free or reduced care to patients who meet the guidelines of our Financial Aid Program.

It has been determined that Financial Aid may be of benefit to you.
Included with this letter you will find the current guidelines as well as an application. Please review and complete application, including any supporting documents, and mail back your application to the below address.

Columbia Memorial Health
PO Box 2000
Financial Counselors
Hudson, NY 12534

A confirmation letter will be mailed to you when we receive your application. Applicants can expect a determination within 30 days and may follow up with a Columbia Memorial Hospital Financial Counselor at (518) 828-8051 with any questions.

Sincerely,

Patient Accounts
Columbia Memorial Hospital
518-828-8051

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Financial Aid Guidelines

Financial Aid is a program administered by Columbia Memorial Hospital that enables patient's to apply for free or reduced health care costs.

Requirements:

- ✓ Residency in Columbia, Greene, Dutchess, Albany, Rensselaer and Ulster Counties for emergent and non-emergent.
- ✓ All New York State Residents are eligible for emergent care services

Eligible Population:

- ✓ Uninsured/Underinsured
- ✓ Exhausted their health insurance benefits
- ✓ Inability to pay full charges
- ✓ Deductibles and Co-Payments

Excluded services:

- ✓ No-fault/Workers Compensation
- ✓ Third Party Liability
- ✓ Pending law suits
- ✓ Private Room Differentials, Television and Telephone Charges
- ✓ Non-covered days
- ✓ Not Medically Necessary Services

Income Guidelines

To be considered your income must be at a percentage of the Federal Poverty Guidelines. All other assets will be taken into consideration. Once a discount is applied, monthly contracted payments must be established.

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Financial Aid Application

I. Patient Information

Patient Name: _____ Date of Birth:_____
Social Security Number:____-___-____ Telephone: (____)____-_____
Street Address/PO Box:_____
City:_____ State:_____ Zip: _____

II. Dates and Type of Services Applying for:

Please list dates and account numbers of services you are applying to be covered under the Uncompensated Care Program.

Date: _____ Account #: _____
Date: _____ Account #: _____
Date: _____ Account #: _____

Total Amount of Outstanding Medical Bills: $_____

III. Financial Information

a. Family Income

1. Self (please list frequency - weekly, monthly, etc.)
   - Wages _____
   - Unemployment _____
   - Child Support _____
   - Workers Compensation _____
   - Social Security _____
   - Public Assistance _____
   - Other _____

*If unemployed, what were you last dates of employment?

_____
_____

Are you eligible for unemployment? Yes or No
Have you applied for unemployment if eligible? Yes or No

2. Spouse or Partner
   - Wages _____
   - Unemployment _____
   - Child Support _____
   - Workers Compensation _____
   - Social Security _____
   - Public Assistance _____
   - Other _____

b. Insurance Information

1. Do you have health Insurance: Yes or No
2. If yes, please list:
   Insurance Provider:_____ Policy ID#:_____
   State where insured:_____
3. Have you ever had Medicaid in NYS? Yes or No
4. If yes, which County did you have Medicaid through?_____
5. Have you recently applied for Medicaid or any other state or Government health insurance? Yes or No
6. If yes, what have you applied for: _____

c. Assets:

Saving Account $_____(please attach statement)
Checking Account $_____(please attach statement)
Cash $_____
Stocks & Bonds $_____
Insurance Policy $_____(cash value)
Pension $_____
Other $_____ Description

d. Family Size

_____ (A family size is established by those who are married or claimed as a dependent on another's tax return)

IV. Required Document Check List

Please include with this application the following documents, if applicable.

1. Last 3 copies of your paycheck stubs: _____
2. Most recent copy of your social security check: _____
3. Copy of last years completed tax return: _____
4. Proof of Identification/Residency: _____
5. Checking and/or saving account summaries: _____
6. Medicaid Denial: _____

If you were not required to file an income tax return this year, please sign the below affidavit attesting to this:

Signature: _____ Date: _____

I certify that the above information is true and correct and I understand that the information submitted is subject to verification by Columbia Memorial Hospital and audits as required.

Signature: _____ Date: _____

Please keep Columbia Memorial Hospital informed of application process at all times. Failure to do so could result in your account(s) being relinquished to a collection agency. In this instance the application would become null and void. Please refer all questions and concerns to Patient Accounts, which can be reached Monday - Friday, 8am-4pm at (518)828-8051.

Please return completed application to:

Columbia Memorial Hospital
71 Prospect Avenue
Hudson, NY 12534
Attention: Patient Accounts Department

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FOR OFFICIAL USE ONLY:

Date Application Mailed: _____
Date Application Received: _____
Staff Member Reviewing: _____
Date Approved: _____
Approved By: _____
Percentage Approved: _____
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