

UNCOMP CARE APPLICATION 2011 - BLANK.txt

Columbia Memorial Hospital  
P.O. Box 2000  
Hudson, NY 12534

To Whom It May Concern:

Columbia Memorial Hospital, as a community service, may provide free or reduced cost care to patients who meet the guidelines of our charity care program - Uncompensated Care.

It has been determined that Uncompensated Care 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 attention of the Cashier's Office at Columbia Memorial Hospital.

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) 828-8523 with any questions.

Sincerely,

Patient Accounts  
Columbia Memorial Hospital  
518-828-8523

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Columbia Memorial Hospital  
Uncompensated Care Guidelines

Uncompensated Care 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.
- Medicaid or Facilitator Enroller denial is required for all applications. The Department of Social Services requires applications to be filed within 90 days of rendered services.

Eligible Population:

- Uninsured
- Exhausted their health insurance benefits
- Inability to pay full charges

Excluded services:

- Accounts in collections
- 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 the below guidelines. All other assets will be taken into consideration. Once a discount is applied, monthly contracted payments must be established.

Family Size	Income (based on 2011 poverty guidelines)
1	\$43,560.00
2	\$58,840.00
3	\$74,120.00
4	\$89,400.00
5	\$104,680.00
6	\$119,960.00
7	\$135,240.00
8	\$150,520.00

Approved uncompensated care discounts are for Columbia Memorial Hospital bills

only.

Columbia Memorial Hospital  
Uncompensated Care 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. Current copies of your CMH statements: \_\_\_\_\_
- 6. Checking and/or saving account summaries: \_\_\_\_\_
- 7. 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)828-8523.

Please return completed application to:  
Columbia Memorial Hospital  
71 Prospect Avenue  
Hudson, NY 12534  
Attention: Patient Accounts Department



FOR OFFICIAL USE ONLY:

Date Application Mailed: 07/18/11

Date Application Received: \_\_\_\_\_

Staff Member Reviewing: \_\_\_\_\_

Date Approved: \_\_\_\_\_

Approved By: \_\_\_\_\_

Percentage Approved: \_\_\_\_\_