

CONFIDENTIAL

River Care Program Financial Assistance Packet

Sponsored by:

**River Hospital, Inc
4 Fuller Street
Alexandria Bay, NY 13607
(315) 482-2511**

“Serving our Community with Pride”

<p><i>For Office Use Only</i></p> <p><i>Name:</i> _____</p> <p><i>Date Applied:</i> _____</p> <p><i>Date Returned:</i> _____</p> <p><i>Date Approved:</i> _____</p> <p><i>Date Denied:</i> _____</p> <p><i>% of Discount:</i> _____</p>	<p><i>Initials:</i> _____</p>
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River Hospital *Serving the Thousand Islands Region*

4 Fuller Street • Alexandria Bay • New York • 13607

315-482-2511 telephone

315-482-4981 facsimile

Thank you for your interest in the River Hospital financial aid program on _____ .
Date

River Hospital serves a large geographical area of the mainland of the Thousand Island region, and a seasonal and tourist population. The River Hospital's general service area reaches a radius of approximately twenty five miles, and includes several surrounding communities.

River Hospital is dedicated to providing quality care to our patients with financial assistance to those who may need help paying for their healthcare. Financial aid is available to patients with no insurance or whose health care benefits have been exhausted. River Hospital does not provide additional assistance with copays and deductibles after insurance payments. This packet provides you with the tools you need to apply for financial assistance with your hospital bill(s). Patients are expected, however, to contribute to their healthcare costs based on their ability to pay so, please complete the application in its entirety and submit all requested documentation to avoid delays or denial of assistance. *Patients may apply for assistance within 90 days of discharge or date of service.*

Once the application is requested and received by the applicant, the application must be returned to River Hospital within 20 days. The application cannot be processed without the following documentation:

- Completed application
- Copies of your most recent 2 pay stubs
- Copy of last year tax return
- Copy of Medicaid denial within the past 3 months

River Hospital will not pursue further collection action while this application is in process providing you return the application timely with the required documentation. If you need additional time you must contact River Hospital at 482-1230. Please provide an explanation below for any documentation you are unable to provide:

River Hospital will process this application within 30 days of receipt. You will be notified in writing of our decision and any remaining balance on your accounts. An installment agreement will be sent with your notification if you have any remaining balances due to River Hospital. This is an interest free agreement that will need to be signed and returned.

You have the right to appeal the Hospital's determination of financial aid if you disagree with the decision or feel you have additional hardships that should be considered. A Notice of Right to Appeal will also be included with your notification of the Hospital's decision.

Financial aid discounts will be determined as follows:

- *Individuals or families at or below 100% of the federal poverty level (FPL) will receive a 100% discount of charges leaving no patient responsibility.*
- *Individuals or families from 101% to 150% of FPL will receive a discount of 80% of the capped charges, leaving a patient responsibility of 20% of capped charges.*
- *Individuals or families from 151% to 200% of FPL will receive a discount of 60% of the capped charges, leaving a patient responsibility of 40% of capped charges.*
- *Individuals or families from 201% to 250% of FPL will receive a discount of 40% of the capped charges, leaving a patient responsibility of 60% of capped charges.*
- *Individuals or families from 251% to 300% of FPL will receive a discount equal to that of the highest volume third party payer, leaving a patient responsibility equal to capped charges.*
- *Hospital charges will apply to individuals or families above 300% of FPL.*

If you have any questions regarding this application, please call Cherie at 482-1230 weekdays between 8:00 AM and 4:00 PM.

APPLICATION FOR FINANCIAL ASSISTANCE
River Hospital, Inc.

Please answer all questions completely
(Please Print or Type)

Date: _____ **Social Security Number:** _____

Patient(s) Name: _____
Address: _____

Guarantor Name: _____	SSN: _____
Address: _____	Phone #: _____
Relationship to Patient:(s) _____	Number of Dependents: _____
Employer: _____	Years There: _____
Position: _____	
Address: _____	Phone: _____
Present Gross Salary: _____	Per: Weekly/Bi-Weekly/Monthly
	(Circle One)
If you are unemployed do you expect to return to work? _____	

Spouses Employer: _____	Years there: _____
Position: _____	
Address: _____	Phone #: _____
Present Gross Salary: _____	Per: Weekly/Bi-Weekly/ Monthly
	(circle one)

Other Income: Social Security V.A. Welfare (circle one if applies)	
Other : _____	
Any Other Income: \$ _____	Per: Weekly/Bi-Weekly/Monthly
	(circle one)

ASSETS: Do you own or rent your home? _____ **Monthly Payment:** _____

Name of Landlord/mortgage holder: _____

Address: _____ **Phone:** _____

Approximate market value (if you own)? _____ **Are payments current?** _____

Other Real Estate owned? _____ **Are payments current?** _____

Equity: _____

Location: _____

Automobile(s)

Make: _____ **Year** _____ **Current Value \$** _____ **Balance** _____

Make: _____ **Year** _____ **Current Value \$** _____ **Balance** _____

Do you own a boat? _____ **Camper?** _____ **Equity:** _____

Applicable Resources:

Checking Account Number(s)

_____ **Institution/Branch:** _____ **Balance:** _____

_____ **Institution/Branch:** _____ **Balance:** _____

Savings Account: Number(s)

_____ **Institution/Branch:** _____ **Balance:** _____

_____ **Institution/Branch:** _____ **Balance:** _____

Cash on hand: \$ _____ **Certificates of Deposit: \$** _____

Savings Bond: \$ _____ **Stocks and or/Bonds:** _____

Accumulated Dividends on Life Insurance Policies: \$ _____

Money Market Accounts: \$ _____

Monthly Household Expenses:		Yearly Household Expenses:	
Mortgage/Rent	\$ _____	School/Land Taxes	\$ _____
Electric	\$ _____	House Insurance	\$ _____
Heat	\$ _____	Vehicle Insurance	\$ _____
Cable/Satellite	\$ _____	Health Insurance	\$ _____
Water Sewer	\$ _____	Life Insurance	\$ _____
Telephone	\$ _____	Cell Phone	\$ _____

OTHER DEBTS

Type:	Owed To:	Present Balance:	Will be paid off by:	Monthly Payment:
Bank Notes				
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
Personal Loans:				
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
Credit Cards				
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
Medical Bills				
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Please indicate any references we may contact to verify your hardship.

1. _____ **Address:** _____

_____ **Phone:** _____

2. _____ **Address:** _____

_____ **Phone:** _____

In signing this application, I swear and affirm that the information I have given or have been requested to give River Hospital, Inc. as a basis for reduced payments or Charity Care is true and correct.

(Guarantor's Signature)

(Date)

(Spouse's Signature)

(Date)

Requested/Sent: _____

Received: _____

River Hospital, Inc.
2011 Financial Aid Policy Guidelines
2010 Federal Poverty Levels and Capped Charges

Family Size	SPCHARFULL		SPCHAR80CP		SPCHAR60CP		SPCHAR40CP		SPCHARCAPD	
	100% of FPL		101% - 150% of FPL		151% - 200% of FPL		201% - 250% of FPL		251%- 300% of FPL	
	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual
1	908	10,890	1,362	16,344	1,816	21,792	2,270	27,240	2,724	32,688
2	1,226	14,710	1,839	22,068	2,452	29,424	3,065	36,780	3,678	44,136
3	1,544	18,530	2,316	27,792	3,088	37,056	3,860	46,320	4,632	55,584
4	1,863	22,350	2,795	33,534	3,726	44,712	4,658	55,890	5,589	67,068
5	2,180	26,170	3,270	39,240	4,360	52,320	5,450	65,400	6,540	78,480
6	2,499	29,990	3,749	44,988	4,998	59,976	6,248	74,970	7,497	89,964
7	2,818	33,810	4,227	50,724	5,636	67,632	7,045	84,540	8,454	101,448
8	3,136	37,630	4,704	56,448	6,272	75,264	7,840	94,080	9,408	112,896
Each additional member	3,820	45,840	5,730	68,760	7,640	91,680	9,550	114,600	11,460	137,520
Patient Balance*	\$0.00 – no balance		20% of capped charges		40% of capped charges		60% of capped charges		100% of capped charges	

*Anticipated patient responsibility after completion of the River Hospital Charity Care Application and approval by Financial Aid Committee.

Capped Charges:

River Hospital, Inc. caps charges for Financial Aid at the payer rate for the highest volume third party payer for the prior year. That third party payer contracted reimbursement rate was 80% of hospital charges for outpatient services and DRG calculation for inpatient stays.

Example: A patient at 135% of the poverty level submits an application and is approved for a 80% discount with a patient responsibility of 20% of capped charges. If the total hospital outpatient charges are \$100, the patient responsibility would be \$16.00
(\$100 charges x 80% = capped charges of \$80 x 20% patient responsibility = \$16.00)

Ask a registration clerk for a Financial Aid Packet if you are unable to pay your bill or feel you meet the guidelines above. You may also call the Financial Counselor at River Hospital directly at 482-1230 if you have any questions. Ask for Cherie.

To be posted in the River Hospital lobby and River Community Clinic waiting area. Also to be included in the River Hospital Financial Aid Packet.