



**BENEDICTINE
HOSPITAL**

KINGSTON HOSPITAL

**MARGARETVILLE
HOSPITAL**

**Application for Hospital Financial Assistance (Effective October 1, 2009)
(Completed application must be submitted within 20 working days with proof of income.)**

Name:		Street Address:		City, State, Zip	
Soc Sec #:		Phone (home/cell)		Phone (work)	
Account#	Balance \$	Account #	Balance \$		
Account #	Balance \$	Account #	Balance \$		

Have you applied for Medicaid? _____ Yes _____ No If no, why not? _____

Briefly describe your financial situation: _____

DEPENDENTS:

Name	Age	Relationship

ANNUAL INCOME:

Patient Income:	Spouse Income:	Other Family Members' Income:
Social Security:	Pension:	VA Benefits:
Alimony:	Child Support:	Public Assistance:
Unemployment:	Compensation:	Other:

NOTE: Federal income tax return, and last two pay stubs must be enclosed with this application to document patient and family income. If Social Security is your only income, submit a copy of the Social Security statement, copy of the Social Security check or a copy of your bank statement showing direct deposit of Social Security payment.

I certify that the above information is true and accurate to the best of my knowledge. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and require full and immediate payment of this debt.

I give my permission to Health Alliance of the Hudson Valley to disclose this information to any Federal or State agency responsible for determining program compliance.

Date of Request

Applicant's Signature

**INDIVIDUAL NOTICE OF AVAILABILITY OF
FINANCIAL ASSISTANCE 2009**

Health Alliance of the Hudson Valley provides a reasonable amount of its services at a reduced charge or no charge to eligible persons who request those services. Financial Assistance will be available to persons whose family income is not greater than the Federal Poverty Income Guidelines listed below, and applies to hospital bills only. Private physician fees are not covered under this program.

		% of Income			
Family Size	HHS Poverty Income \$	150%	250%	300%	
	1	10,890.00	16,335.00	27,225.00	32,670.00
2	14,710.00	22,065.00	36,775.00	44,130.00	
3	18,530.00	27,795.00	46,325.00	55,590.00	
4	22,350.00	33,525.00	55,875.00	67,050.00	
5	26,170.00	39,255.00	65,425.00	78,510.00	
6	29,990.00	44,985.00	74,975.00	89,970.00	
7	33,810.00	50,715.00	84,525.00	101,430.00	
8	37,630.00	56,445.00	94,075.00	112,890.00	
% of Discount	100%	80%	50%	25%	

**For families with more than eight members, add \$3,820 for each additional member.

If you think you may be eligible, please submit this completed application **with your most recent Federal Tax return and last 2 pay stubs** to:

Health Alliance of the Hudson Valley
Attention: Patient Accounting Dept.
741 Grant Ave.
Lake Katrine NY 12449

A written conditional or final determination of your eligibility will be made within 30 days following receipt of the application. Questions should be directed to 845-334-2743. Once you have submitted this application, please disregard any bills until you receive our response.

DO NOT WRITE BELOW THIS LINE

A. Total Family Annual Income	\$
B. Family size of _____	
Eligible Discount Percentage	%

Account#	\$ Amount	Discount %	Discount Amount \$	Patient Balance\$

Total Financial Assistance approved \$ _____

Approved/Denied by _____ (date) _____ Denial reason _____