HealthAlliance's Application for Hospital Financial Assistance

HealthAlliance of the Hudson Valley includes its charity care application on the back of every patient bill. The health system, which is located in upstate New York, offers charity care based on established guidelines from the state of New York, which describe a sliding scale for patients earning up to 300 percent of the federal poverty level. For example, if a family of four has a household income of $34,575, that family would qualify for an 80 percent discount on its medical bill.

Source: HealthAlliance of the Hudson Valley, 2012. Reprinted with permission.

I AUTHORIZE KINGSTON HOSPITAL TO CHARGE MY OBLIGATION TO THE CHARGE CARD BELOW.

Please charge my ☐ VISA ☐ MasterCard ☐ DISCOVER NOVUS ☐ AMERICAN EXPRESS

American Express Visa/MC/Discover

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Account # Expiration Date Security Code Security Code

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Card Holder Name (please print) Billing Zip Code Amount

Signature Date

PLEASE SUBMIT THIS BILL TO THE INSURANCE COMPANY LISTED BELOW

Insurance Company Name Group #

Insurance Company Address Identification #

Subscriber Name Subscriber Date of Birth

Effective Date

▲Please Enclose This Portion With Your Payment▲

Application for Hospital Financial Assistance

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