ADIRONDACK HEALTH
Better Health, Better Lives

Financial Assistance

Dear Applicant,

Thank you for choosing Adirondack Health as your health care provider.

If payment of your medical bills creates a financial hardship for you, you may be eligible for financial assistance through Adirondack Health's Financial Assistance Program. Our staff are here to help you and are willing to work through the process with you. Please note that before any financial assistance can be provided by Adirondack Health, our staff will work with you to identify other sources of payment.

The following criteria must be met to be eligible for financial assistance from Adirondack Health:

- You must be a permanent resident of New York State.
- The services that were provided to you must be considered medically necessary essential health care services. Elective and cosmetic services are not eligible.

The following types of services are **not** eligible for financial assistance

- Elective/Cosmetic services - unless medically necessary based upon diagnosis with physician review
- Birth control, infertility treatments, fertility services, sterilization and reversal of sterilization.
- Services to residents outside of the financial eligibility area **unless** provided in an emergency room setting
- Services reimbursed directly to you by your insurance carrier or already covered by a third party
- Services provided by medical personnel who are not employed by Adirondack Health (i.e. radiologist, anesthesiologist, surgeons, orthopedics, internal medicine, psychiatry, pathologists, etc.)

Household income & family size must be within the guidelines.

If you meet the criteria and wish to apply for Adirondack Health's Financial Assistance, please complete the enclosed application form. Please note, you will continue to be financially responsible for all services you receive until it is determined you qualify for assistance. **All completed application are acknowledged within 30 days, informing the patient of the decision regardless of assistance awarded.**

We are here to help, if you have any questions or require aid in understanding any part of the application process please contact a member of our team at 518-897-2217 or contact us by email at: billing@adirondackhealth.org. For help in completing the application, a Financial Counselor is available M-F, 8:30 am - 4:00 pm by appointment. Completed applications should be forwarded to the following address:

Adirondack Medical Center
Attn: Financial Counselor
P.O. Box 1380
Saranac Lake, NY 12983

ADIRONDACK HEALTH
Better Health, Better Lives

Financial Assistance

Helpful Information:

Verification of New York state residency

a. A copy of the applicant's driver's license and/or NYS ID card to verify NYS residency. Please make sure that the address on the license/ID is the current address.
b. If no driver's license or ID card is available a utility bill will suffice, but it will need to show current address.

If you are **uninsured**, a screening is encouraged to take place with a designated Market Place Health Exchange Navigator. A screening can either be done by phone or in-person. No appointment necessary.

Navigator:
Debbie Hughes
Contact No.: 518-225-8163
Email: debbie.hughes@excellus.com

Ashlee Brown
Contact No.: 518-424-8397
Email: ashlee.brown@fideliscare.org

Adirondack Health Office 518-897-2725

If the patient is currently without insurance but will have coverage in the future, a Determination Notice will need to be included. The patient will still be eligible for Financial Assistance even though his/her coverage won't start until a later date.

ADIRONDACK HEALTH
Better Health, Better Lives

Financial Assistance

Applicant's Information:

Applicant Last Name	First Name	Middle Initial	-- -- Social Security Number *(optional)*	/ / Date of Birth

Address	City	State	Zip	Phone Number ☐ Land Line ☐ Cell

Employer or check one: ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Marital Status - Please check one: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
(optional)

Spouse/SO Last Name *(optional)*	First Name	Middle Initial	-- -- Social Security Number	/ / Date of Birth

Spouse/SO Employer *(optional)* or check one: ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Household Information:

Please list below all dependents who live in your household. Do not include non-dependents who reside in your household.

NOTE: You may include dependents for which you provide at least 50% support and who are reflected as dependents on your Federal Income Tax Returns.

Last Name	First Name	Date of Birth	Relationship
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

Monthly Expenses:

Rental or Mortgage Payment: _____ Real Estate Debt: _____

Property Tax Amount Not Included in Payment Amount Above: $_____

Utilities	$	Credit Card	$	Insurance (Auto/Life/Property)	$
Auto	$	Health Insurance	$	Alimony/Child Support	$
Child Care	$	Healthcare Bills	$	Other:	$
Living (food/gas)	$	Medications	$	Other:	$

Extenuating Expense Circumstances: _____

ADIRONDACK HEALTH
Better Health, Better Lives

Financial Assistance

Income:

Monthly Income From: Name of household member:	Person 1	Person 2	Documentation required for verification
Gross Salary Wages	$	$	2 consecutive pay stubs/ employer pay statement
Self Employed	$	$	Tax return plus current YTD Profit & Loss
Public Assistance	$	$	Award letter, check stub, bank statement, etc.
Social Security	$	$	Award letter, check stub, bank statement, etc.
Unemployment/Workers' Compensation	$	$	Check, bank statement, online, etc.
Alimony/Child Support	$	$	Cancelled check, garnishment, bank statement, etc.
Pension/Retirement Income	$	$	Bank statement or Pension check stub
Disability	$	$	Check, bank statement, online, etc.
Rental Income	$	$	Schedule E of IRS tax form
Dividend Income	$	$	Current/quarterly statement from financial institution
Other Income	$	$	Contact FAP Specialist
Total:	$	$	

Cash, Savings and Investments: *(optional)*

Checking Account Balances	$	$	Bank statement
Savings	$	$	Bank statement
CD Account Balances	$	$	Copy of statement
Bonds	$	$	Copy of statement or bond
Annuities	$	$	Copy of statement
Money Market	$	$	Copy of statement
Trust Account	$	$	Copy of statement
Stocks/Mutual Funds	$	$	Copy of statement
Other – Specify: _____	$	$	Contact FAP Specialist
Total:	$	$	

Please Read Carefully:

I am requesting financial assistance from Adirondack Health. I verify that all information I have provided is accurate and complete. Adirondack Health has my permission to pursue verification of pertinent information and exchange information regarding my accounts, application and supporting documentation with its affiliated providers. Any incorrect, incomplete or false information provided may cancel my application for financial assistance. I agree to repay the full financial assistance award if I receive payment of any kind for the medical services covered by this financial assistance application. All information provided will remain confidential under the provisions of HIPAA federal regulations.

Applicant's Signature Date:

FOR OFFICE USE ONLY: ☐ **Denied** ☐ **Approved** **Discount approved:** ☐ **100%** ☐ **40%** ☐ **35%** ☐ **30%** ☐ **20%**

Financial Counselor Signature Date Received:

PFS Manager/Director Signature Date:

AVP of Revenue Cycle/CFO Signature (>$20,000) Date: