St. LUKE'S CORNWALL HOSPITAL
A Member of the Montefiore HEALTH SYSTEM, INC.

Date: _____

Dear Patient/Guarantor:

It has come to our attention that you may be in need of financial assistance at this time. We at St. Luke's Cornwall Hospital recognize this need and are here to assist you whenever possible. To assess whether or not you qualify for financial assistance we require a completed application (see attached) along with proof of income.

Please provide:
2 of the following proofs of income be provided to our office for review:

1. Wages - Copy of pay stubs for the past three (3) months for all family members who are employed
2. Unemployment compensation letter
3. Workers compensation determination letter
4. Retirement/Pension determination letter
5. All Bank Statements for three (3) months
6. Copy of Denial letter from Medicaid

OR 1 of the following:

1. Copy of your most recent W-2 and/or tax return
2. Social Security/Disability determination letter

If you are unable to provide income documentation for the last year, as noted above, please provide us with a notarized self attestation of income which can be considered in appropriate circumstances. Applications must be completed in full and signed for consideration. **Incomplete applications will be denied.**

St. Luke's Cornwall Hospital offers Financial Assistance based on your family size and income. Depending on your qualifications, you may be approved for 100% discount, or 50% discount. If you are approved for a 50% discount, or denied due to being over the income guidelines, a modified payment plan will be extended to you, not to exceed 10% of your monthly income. You will receive correspondence related to these arrangements in writing from our office.

Qualifications for Eligibility are as follows:
Patients with a demonstrated family income at or below 200% of the published Federal Poverty lines are eligible for 100% discount on any qualifying balances. Patients with a demonstrated family income between 201% and 300% of the federal poverty line are eligible for 50% discount on qualifying balances.

Patients may not be denied access to emergent or medically necessary care based on ability to pay, and individuals may not be charged more than the facility's generally billed amounts. For those patients who are uninsured, these amounts are equal to 100% of the current Medicare rates.

Please include all current outstanding statements from St. Luke's Cornwall Hospital along with this application. Please note that you may continue to receive bills regarding your outstanding account(s) during this process, however no collection activity will take place until your approval/denial is determined.

This Financial Assistance Application only applies to services billed by the hospital. Other services which are billed separately are not eligible under this application. For outstanding Physician statements please contact these groups directly regarding their individual financial assistance programs or payment plan arrangements.

Please complete and return the requested information to our Credit/Collection Office within 240 days from your date of service. Upon receipt of all information, determination of financial assistance will be decided within 30 days. If you are unable to provide information within 240 days and we do not receive correspondence regarding this matter, we will consider your request withdrawn.
Upon full or partial approval and/or denial you will receive a letter of determination.

If you need further assistance please visit or call: St. Luke's Cornwall Hospital, Credit and Collection Department located at 19 Laurel Avenue Cornwall, NY 12518, Monday through Friday 8 am-4pm or by appointment. We can be reached by phone at 845-458-4900

Thank you,
St. Luke's Cornwall Hospital

St. Luke's Cornwall Hospital
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Please answer all questions completely and to the best of your knowledge to prevent delaying this application. Copies of proof of income MUST be attached or application will be rejected as incomplete.

IF ALL AREAS ARE NOT COMPLETED, THE APPLICATION WILL BE REJECTED.

Patient Name: _____ Birth date: _____
Primary telephone #: _____ Alternate telephone #:_____
Address: _____ # of Years: _____
City: _____State:_____ Zip: _____
Resident of NY (Y/N): _____
Marital Status: _____
Spouse's Name: _____ Birth date: _____

Account Number ***(Hospital only)***	Amount Due:
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
Total Financial Assistance Requested	$

Household and Employment Information

List all persons living in household.

Name	Relationship/Age	Insurance Coverage?

Was this visit to the Hospital related in any way to an on the job or occupational injury or disease? _____

If yes, please explain: _____

Are you presently employed: Patient (Y/N): _____ Part Time: _____ Full Time: _____
Spouse (Y/N): _____ Part Time: _____ Full Time: _____

Patient's current employer: _____
Employer Address: _____
Position: _____ Supervisor: _____
Phone: _____Length of employment_____ Retired (Y/N): _____

Spouse's current employer: _____
Employer Address: _____
Position:_____ Supervisor: _____
Phone: _____Length of employment_____ Retired (Y/N): _____

If unemployed, list past employment:

Patient's	Spouse's
Employer: _____	Employer: _____
Phone: _____	Phone: _____
Date Last Employed: _____	Date Last Employed: _____

Monthly Household Income & Expenses

Household Monthly Income

Wages/Salary:	$	Unemployment:	$
Tips:	$	Income Other: (Please explain)	$
Alimony/Child Support:	$	Pension/Retirement:	$
Social Security:	$	Dividends/Interest/Rent:	$

Total Income: $_____

Current place of residence: Own ___ Rent ____Other____

Applicant Other Than Patient

If applicant is different that patient, please explain:

_____
_____

If patient is deceased, please complete the following:
1. Date patient expired _____/_____/_____
2. Is there a surviving spouse? (Y/N) _____. If yes, name and address of surviving spouse:

_____
_____
3. Is there an estate? (Y/N) _____
4. How was this verified? _____
5. Name of persons making application: _____
6. Relationship to patient: _____

I/We agree that this application will remain the property of St Luke's Cornwall Hospital whether or not assistance is granted.
I/We hereby authorize St. Luke's Cornwall Hospital to verify my/our credit and employment history.
I, the undersigned, do acknowledge all information is true and accurate to the best of my knowledge. This is a request for uncompensated care of services provided at St. Luke's Cornwall Hospital.

Applicants Signature: _____Date: _____

Spouse's Signature: _____Date: _____