FINANCIAL ASSISTANCE APPLICATION

Applicant's Name: _____

Address: _____ City: _____ State/Zip: _____/_____

Phone: ( ) _____

Family Members: (Spouse, dependents claimed on Federal Tax return and their date(s) of birth):

Name:	Date of Birth:	Name:	Date of Birth:
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Applicants must submit all relevant documents with application within 30 days for determination.

THE FOLLOWING DOCUMENTATION IS REQUIRED TO DETERMINE ELIGIBILITY

1. Proof of Income: (submit all documentation that applies to your household)

- ☐ Pay Stubs: Provide last 3 months of pay stubs or wage documentation, including spouse, if applicable
- ☐ Last federal tax return
- ☐ Unemployment: provide current award letter with name and date, if applicable
- ☐ Workers Compensation: copy of wage statement, if applicable
- ☐ Social Security: benefit award letter, if applicable
- ☐ Pension: statement or 1099 form, if applicable
- ☐ Other forms of income: short/long term disability, interests/dividends, retirement income, child support, alimony and/or public assistance, if applicable
- ☐ Self Employed: prior year's income tax return

2. Proof of No Income: provide a signed, dated statement explaining how your needs are met

3. Proof of Health Insurance: Do you have health insurance?

☐ Yes, attach copy of insurance cards ☐ No

I affirm by my signature below that the information contained on this application is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility. I agree to inform St. Joseph's Health promptly of any changes in my needs, income and living arrangement or address.

Applicant's Signature: _____

Date: _____

MAIL ALL INFORMATION TO:

St. Joseph's Health Hospital
Attn: Benefit Advocacy/Patient Registration
301 Prospect Ave
Syracuse, NY 13203

ST. JOSEPH'S HEALTH
A Member of Trinity Health

Benefit Advocacy
Mon-Fri 8AM-4:30PM
315.448.3555
sjhsyr.org/financial-assistance

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FINANCIAL ASSISTANCE PROGRAM

St. Joseph's Health is committed to caring for patients regardless of their ability to pay.

Health care bills can be daunting, especially to those who do not have insurance to pay for them. At St. Joseph's Health we understand how confusing medical bills can be to and have trained benefit advocates who can help you understand your financial responsibility and the payment options available to you.

Our patient financial assistance program helps people who are unable to pay all of their medical bills incurred at St. Joseph's Health. Patients may also qualify for financial assistance if they do not have health insurance of it their health insurance does not cover all the medical care they need.

Short Term and Long-Term Payment Plans
Patients who cannot pay some or all of their financial responsibility may qualify for short term or long-term payment plans and loans.

Patients may qualify for one of the options below:

- Balances paid in less than 90 days may be eligible for an interest free payment plan.
- Balances paid in 120 days to 12 months may be eligible for a zero-interest loan program.
- Balances that will need to be paid in a time frame greater than 12 months may be eligible for a low interest loan program.

ELIGIBILITY FOR FINANCIAL ASSISTANCE

Applicants for financial assistance may be screened for Medicaid eligibility by a benefit advocate. Income verification for the time frame in which you received services will be needed to determine whether a state sponsored insurance application should be completed.

No one will be denied access to services due to the inability to pay, a discounted sliding fee schedule is available based on family size and income and not on insurance application status.

OUR SERVICE AREA

St. Joseph's Health will extend financial assistance to all eligible patients listed across all Trinity Health Ministries' service market areas constituting a "community of need" for primary health care services

2022 Federal Poverty Levels

	Percent of Poverty Guidelines	
Family Size	**200%**	**400%**
1	27,180	54,360
2	36,620	73,240
3	46,060	92,120
4	55,500	111,000
5	64,940	129,880
6	74,380	148,760
7	83,820	167,640
8	93,260	186,520

For Families/Households with more than 8 persons, add $4,720 for each additional person

FINANCIAL ASSISTANCE AND CHARITY CARE POLICY

A 100 percent discount for medically necessary services is available to patients who earn 200 percent or less of the Federal Poverty Level guidelines. Elective services such as cosmetic surgery are not included in our charity program. Those who earn between 200 and 400 percent of the Federal Poverty Level guidelines may be eligible for a partial discount equal to the Medicare discount rate. Patients who qualify for financial assistance will not be charged more than the Medicare discount rate. Patient copays and deductibles may be eligible for discounted rates if a patient qualifies for financial assistance and earns less than 200 percent of the Federal Poverty Level Guidelines. Services such as cosmetic procedures, hearing aids and eye care that normally are not covered by insurance are priced at package rates with no additional discount. All payments are expected at time of service.

Discounts are also available for those patients who are facing catastrophic costs associated with their medical care. Catastrophic costs occur when a patient's medical expenses for an episode of care exceed 20% of their income. In these cases, patient copays and deductibles may also be included in the discount. Charity care discounts may be denied if patients are eligible for other funding sources such as Health Insurance Exchange plan or Medicaid eligibility and refuse or are unwilling to apply.

THE APPLICATION PROCESS

- For additional assistance please call 315.448.3555. (Mon-Fri 8AM-4:30PM)
- You may also download a financial assistance application at sjhsyr.org. Once completed the application should be mailed to:
  St. Joseph's Health Hospital
  Attn: Benefit Advocacy
  301 Prospect Ave
  Syracuse, NY 13203
- The application must be completed within 240 days from the patient's first post discharge billing statement.
- Once an application is received you will have an additional 30 days to submit the required documentation. If documentation is not submitted within 30 days of the request, the application will be considered withdrawn. Your application will be reviewed and you will be notifed of its decision in writing within 30 days after receipt of completed application. St. Joseph's Health will determine a sliding fee scale for each service based on the Federal Poverty Guidelines and the patient's income level.
- Translator services are available to assist with the application process.
- If fraudulent documentation is submitted any financial assistance may be revoked.
- The determination of eligibility is made dependent upon the documentation submitted.