Section IV: Household Income Information (please print)

Application requires proof of income: Copies of last two months of pay stubs

	Gross monthly income
Family's Gross Monthly Wages	$
Unemployment	$
Workers' compensation	$
Interest/Dividends	$
Child support / Alimony	$
Social Security / Disability	$
NYS Disability	$
Pension	$
Other / Specify (IE: Rental Income)	$
Application Requires proof of income: Copies of pay stubs from the last two months. **TOTAL	$

Section V: Status of Medicaid Eligibility (please print and sign)

Applied for Medicaid? Y ____ N ____

If Yes: ____ Pending ____ Denied (please attach copy of denial) ____ Approved

If Approved: Spend Down $ _____

I hereby give my consent to Oswego Hospital and Oswego County Department of Social Services to exchange information on the OH Financial Assistance Application for the purposes of determining whether my household may qualify for medical bill assistance. I understand that the information will be confidential.

Signature: Date:

Spouses Signature: Date:

Your Application is Not Complete without Proof of Income

Section VI: Required Signature for Processing of Patient Financial Assistance Program Application

I understand that this application for the Patient Financial Assistance Program is confidential and will be used to determine my eligibility for uncompensated services under the guidelines established by Oswego Hospital. I affirm the information provided is accurate and to the best of my knowledge. If any information that has been given proves to be untrue, I understand that Oswego Hospital may re-evaluate my financial status and take appropriate action.

Signature of Responsible Party

- Please disregard bills from Oswego Hospital until you receive our decision.
- Completed financial assistance applications will be considered on prior accounts for at least 240 days from the first billing statement.

Patient Financial Assistance Program

The Oswego Hospital is a not-for-profit facility, which provides medical care to all, regardless of their ability to pay. Oswego Hospital's Patient Financial Assistance Program helps people who are unable to pay all of their medical bills.

You may qualify for discounts on medical expenses through this program if:

- You do not have insurance or if your health insurance does not cover all of the medical care you need
- You are not eligible for Medicaid or any other type of insurance
- You meet the financial criteria

Dear Patient,

At Oswego Hospital we are proud of our mission to provide high quality comprehensive and compassionate healthcare services to meet the needs of our civilian and military community.

If you are worried that you will be unable to pay your Oswego Hospital bill in full, please complete and return the attached application to be considered for our Patient Financial Assistance Program.

If you have not recently applied for Medicaid/Child Health Plus/Family Health Plus, please sign the consent in section VI of the application, allowing us to exchange information with the Department of Social Services. In addition to recent pay stubs, income verification for the time period of your Oswego Hospital services will be needed to determine whether a state-sponsored insurance application should be completed.

If you have any questions regarding the application, or if you need help filling it out, call our Financial Counselor at 315-349-5533. Please return the application as soon as possible to the address below, or call the Business Office at 315-349-5533 for further assistance.

The amount of the discount varies based on your income and size of your family.

Family Size	100% Poverty Guidelines	300% Poverty Guidelines
1	12,490	37,470
2	16,910	50,730
3	21,330	63,990
4	25,750	77,250
5	30,170	90,510
6	34,590	103,770
7	39,010	117,030
8	43,430	130,290

For family units with more than 8 members, add for each additional member: $4,420.
(These figures are the current income guidelines for all states except Alaska and Hawaii. Alaska and Hawaii guidelines may be found in the Federal Register dated January 2019.)

Oswego Hospital offers financial assistance to all of our patients including those within our primary service area, which includes Cayuga, Jefferson, Lewis, Madison, Oneida, Onondaga, and Oswego counties.

OSWEGO HEALTH

110 West Sixth Street
Oswego, NY 13126
315-349-5511

www.oswegohealth.org

3/2019

Application for Financial Assistance

Section I: General Information (please print)

Patient's Name: Last First Mi			
Address:			
City:		State:	Zip Code:
Home Phone:		Work Phone:	Employed? Y___N ___
County of Residence:		Social Security #:	
Age:	Sex:	Marital Status:	Date of Birth:

Section II: Guarantor Information - Responsible Party (please print)

Is the patient dependent on another person: Y _____ N _____ Relationship to Patient:

Name: Social Security #:

Address:

City:	State:	Zip Code:

Household Members: **(*Supply Proof of Income)**

Name:	Dependent on Pt. Tax Return Y or N	*Employed Y or N	DOB:	Age	Relationship to applicant:	FT Student Y or N

Section III: Employment & Insurance Information - Responsible Party (please print)

Employer:	
Health Insurance Y _____ N _____	Insurance Name:
Policy Holder Name:	
Policy ID Number:	