FINANCIAL ASSISTANCE APPLICATION/DETERMINATION

Patient's Last Name _____First _____MI____ DOB_____

Spouse's Last Name _____First _____MI____ DOB_____

Address _____City/State _____Zip Code _____

Social Security Number _____ (***Optional***) Phone # (Home) _____ (Work) _____

Employer _____

Household Size _____ (number of individuals residing in applicant's home)

	Last 12 Months	Last 3 Months
Patient's Gross Income	_____	_____
Other Family Income	_____	_____
Total Household Income	_____	_____

Include income from wages (last 3 months pay stubs), tax forms for prior year, self-employment, unemployment, social security, pension, compensation, public assistance, alimony, child support, interest, rental dividends, V.A. Benefits, etc.

Is Patient a dependent on any additional tax forms? Yes ☐ No ☐
If yes, please attach copy of Income Tax Return.

Additional Financial Documentation May Be Requested
Please detail any changes in family circumstances or income for the past (6) six months prior to the date of this application and any expected changes in the (6) six months following this application.

To apply for MVHS Financial Assistance Program, please complete this application form within 90 days from date of discharge, provide all required income documentation in relationship to your family size. If you are requested to apply for Medicaid, the New York Health Exchange or Medicare, you must do so prior to us giving consideration to your application. If you are excluded from Medicaid Coverage due to compliance or criteria, you may be denied from Financial Assistance. The MVHS Business Office will make a final written determination of eligibility within (30) thirty working days after receiving the completed application and all required documentation. For the complete version of MVHS System Financial Aid guidelines, please visit our website at mvhealthsystem.org/billing or call FSLH (315) 624-5170 or SEMC (315) 801-3108 to have a copy sent to you. If you wish to appeal the decision, please contact the applicable Business Office. You may also contact NYS DOH 1(800)-804-5447 or 1(518)-402-6993.

I certify that the above information is true and accurate to the best of my knowledge. Further I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate. I understand that the information, which I submit is subject to verification by MVHS and its Internal auditors.

_____ _____
Date of Request Applicant's Signature

ELIGIBILITY DETERMINATION (For Office Use Only)

Date Application Received _____Period Approved _____

Patient's Assets and Liabilities Not Necessary for Subsistence as Reviewed by Credit Supervisor _____

Documents Received for income verification: W-2's_____Pay Stubs _____ Other _____

Date Application Decision _____Approved _____ Denied _____Authorized Signature_____

Approved: Tier 1 _____Tier 2 _____ Tier 3 _____ (See attached for patient responsibility)

Denial Rationale _____