Dear Patient/Applicant,

The team at St. Mary's Healthcare is committed to minimizing the financial barriers to healthcare that may exist to our patients and community members. Financial assistance is offered for emergencies and other medically necessary care provided to patients who qualify. If you have open balances with St. Mary's, you may benefit from our Financial Assistance Program.

If interested, please complete the application attached. Along with the application, you will need to provide the following information:

- ☐ Completed application
- ☐ Accrued medical bills for past 12 months (e.g., dental, medical billing statements with cost-share amounts)
- ☐ Copies of one month's current pay stubs or proof of alternate income source
- ☐ Copies of last two bank statements
- ☐ Most recent federal tax return
- ☐ Completed application for NYS Medicaid, along with a copy of denial letter if income is more than NYS Medicaid allowable

Incomplete applications will be held, and the applicant will be notified of the missing required information which must be supplied within 30 days from the date of the written notification. If the patient does not meet this requirement, the application will be denied, and the Organization will resume billing and collection activities. The patient retains the option to provide the required information after the 30-day deadline. Applications, if approved, are valid for 180 days and a determination letter will be sent to the address provided.

Discount Example: Underinsured Patient

Patient Balance	50.00
Medical Cost Share (previous 12 months)	200.00
Gross monthly Income (family of 1)	2,000.00
Accrued Medical Cost Share Compared to Gross Monthly Income	10%
Patient Responsibility	10% of Current Patient Balance

Please find the full St. Mary's Healthcare Financial Assistance Policy on our website at **smha.org.** You can also call 518-770-7567 or 518-770-6842 for more information.

Please mail your completed application and documentation to the following address:

St. Mary's Healthcare
ATTN: Patient Financial Services 427 Guy Park Ave
Amsterdam, NY 12010

St. Mary's Healthcare Amsterdam

Financial Assistance Application

Applicant Information:

(Please print, and all fields must be completed. Indicate N/A if not applicable on any individual line in the application.)

Name (first and last) _____
Birth date _____ Phone #_____
Mailing address_____ City_____ State_____ Zip_____
Employer_____Employment status_____ Number of hours worked per week_____

Applicant's Spouse Information:

Name(first and last)_____
Birthdate_____ Phone #_____
Employer_____Employment status_____ Number of hours worked per week_____

Dependents:

Name_____	Birthdate_____	Relationship_____
Name_____	Birthdate_____	Relationship_____
Name_____	Birthdate_____	Relationship_____
Name_____	Birthdate_____	Relationship_____

Monthly Income:

(Fill on dollar amounts for each item below. Provide amounts per month for each.)

Applicants gross Income_____	Child Support Received_____
Spouse Gross Income_____	Alimony Received _____
Social Security Benefits _____	Rental Property Income_____
Pension/Retirement Income_____	Self Employment Income_____
Disability Income_____	Other Income_____
Workers Comp Income_____	No Income: Complete/sign Declaration of no income

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 to determine eligibility. I agree to inform St Mary's Healthcare promptly of any changes in my needs, income, living arrangements or address.

_____
Applications signature

_____
Relationship (if other than patient)

_____
Date

OFFICE USE ONLY
Discount % Approved_____
Date Approved_____
Approval Initials_____