CMH
Columbia Memorial Health
An affiliate of ALBANY MED

To Whom It May Concern,

Columbia Memorial Hospital, as a community service, may provide care at either free or reduced cost to patients who meet the guidelines of our Financial Aid Program.

It has been determined that Financial Aid may be of benefit to you.
Included with this letter you will find the current guidelines as well as an application. Please review and complete the application, and include any supporting document. Please mail the application to the below address.

Columbia Memorial Health
PO Box 2000
Financial Counselors
Hudson, NY 12534

A confirmation letter will be mailed to you when we receive your application. Applicants can expect a determination within 30 days and may follow up with a Columbia Memorial Hospital Financial Counselor at (518) 828-8051 with any questions.

Please keep Columbia Memorial Hospital informed of application process at all times. Failure to do so could result in your account(s) being relinquished to a collection agency. In this instance the application would become null and void. Please refer all questions and concerns to Patient Accounts, which can be reached Monday - Friday, 8am-4pm at (518)828-8051.

Sincerely,

Patient Accounts

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Financial Aid Guidelines

Financial Aid is a program administered by Columbia Memorial Hospital that enables patient's to reduce their out of pocket health care expenses.

Requirements:

- Residency in Columbia, Greene, Dutchess, Albany, Rensselaer or Ulster Counties
- All United State Residents are eligible for emergent care services

Eligible Population:

- Uninsured/Underinsured
- Exhausted their health insurance benefits
- Unable to pay full charges
- Deductibles and Co-Payments

Excluded services:

- No-fault/Workers Compensation
- Third Party Liability
- Pending law suits
- Private Room Differentials, Television and Telephone Charges
- Non-covered days
- Not Medically Necessary Services

Income Guidelines

To be considered your income must be at the below guidelines. All other assets will be taken into consideration. Once a discount is applied, monthly contracted payments must be established.

Family Size	Income (based on 2020-2021 poverty guidelines)
1	$51,040.00
2	$67,640.00
3	$85,320.00
4	$103,000.00
5	$120,680.00
6	$138,360.00

Approved Financial aid discounts are for Columbia Memorial Health bills only.

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Financial Aid Application

I. Patient Information

Patient Name: _____ Date of Birth:_____

Social Security Number:_____-____-_____ Telephone: (____)____-_____

Street Address/PO Box:_____

City:_____ State:_____ Zip: _____

II. Financial Information

a. Family Income

1. **Self** (please list income and indicate; weekly, monthly, etc.)

Wages	$_____
Unemployment	$_____
Child Support	$_____
Workers Compensation	$_____
Social Security	$_____
Public Assistance	$_____
Other	$_____

*If unemployed, what were you last dates of employment?

_____

Are you eligible for unemployment? Yes or No

Have you applied for unemployment if eligible? Yes or No

2. **Spouse or Partner** (please list income and indicate; weekly, monthly, etc.)

Name _____ Date of Birth _____

Wages	$_____
Unemployment	$_____
Child Support	$_____
Workers Compensation	$_____
Social Security	$_____
Public Assistance	$_____
Other	$_____

b. Insurance Information

1. Do you have health Insurance: Yes or No
2. If yes, please list:
   Insurance Provider:_____ Policy ID#:_____
   State where insured:_____
3. Have you ever had Medicaid in NYS? Yes or No
4. Have you recently applied for Medicaid or any other state or Government health insurance? Yes or No
5. If yes, what have you applied for: _____

c. Assets:

Saving Account	$_____	(please attach statement)
Checking Account	$_____	(please attach statement)
Cash	$_____	
Stocks & Bonds	$_____	
Insurance Policy	$_____	(cash value)
Pension	$_____	
Other	$_____	(description)

d. Family Size

_____ (A family size is established by those who are married or claimed as a dependent on another's tax return)

III. Required Document Check List

Please include with this application the following documents, if applicable:

- ☐ Last 3 copies of your paycheck stubs, indicating gross income
- ☐ Most recent copy of your social security check
- ☐ Copy of last years completed tax return
- ☐ Proof of Identification/Residency
- ☐ Checking /Saving account most recent monthly statement
- ☐ ~~Medicaid Denial~~

If you were <u>not</u> required to file an income tax return this year, please sign the below affidavit attesting to this:

Signature: _____ Date: _____

I certify that the above information is true and correct, and I understand that the information submitted is subject to verification by Columbia Memorial Hospital and audits as required.

Signature: _____ Date: _____