Where your health comes first!

Dear Patient and Family Member(s):

Community Memorial Hospital District which includes Community Memorial Hospital, Syracuse Medical Center, Weeping Water Medical Center, and Community Health Services will provide medically necessary services to all patients regardless of financial status. We know that medical bills are often unexpected and may be difficult to pay. Interest free short term payment plans are available on current accounts. If paying your bill creates financial hardship, you may apply for additional assistance. Assistance will apply to any current accounts with Community Memorial Hospital District and will be held for review on continued services for an additional 6 months. A new application will be required for services after 6 months of the dated application. Initial qualification is assessed in accordance to net assets and gross income.

If you qualify, a percentage of your bill may be reduced. To be considered for financial assistance, you must provide the following:

1. Completed Assistance Application
2. Copies of your most recent Federal Income Tax Return
3. Copies of your most recent pay stubs
4. Additional Financial Information copies
5. Verification that you have applied for private, state, or federal programs.

Please attach any additional information that may help us review your financial situation.

Completed applications will be confidentially reviewed. If you have any questions or concerns, please call 402-269-2011.

Sincerely,

Jennifer Beckman
Business Office Director
Community Memorial Hospital

Community Memorial Hospital

Assistance Application

This information is confidential. Please complete all information, attach copies of supporting documents, sign, date, and return form by: _________.

Patient Name(s): List all patients that you are a guarantor for, even if there is not current balance, as this application is valid for 6 months.

____

Guarantor Name and Address:

____

____

____

Phone #: _________________**Date of Birth:** ___________________

SSN #: __________________

Guarantor Employer: _______________________________________

Occupation

Employers Address: _______________________________________

Employers Phone: ____

Marital Status: ____________________

If Married or Separated, Spouse's name: ______________________

Spouse's Employer: _______________________________________

Occupation

Address: _______________________________________

Phone: ____

Number of persons in the household: Including applicant and eligible dependants you are allowed to claim on your tax return.

___Adults ___Children

Have you ever filed for bankruptcy: ___No ___Yes, Date: _______

Please indicate if you have included the following documentation:

Latest Tax Return: _____No _____Yes, Year: ____________

Proof of current income: _____No _____Yes

Financial Information: Attach copies for proof of financial information

Monthly Income for Household: $_________________
(Please indicate with an X who provides income)

Type of Income	**Guarantor**	**Spouse**	**Other**	**Total**
Monthly Income(combined)				
Public Assistance				
Social Security				
Unemployment				
Worker's Compensation				
Alimony				
Child Support				
Pension/Retirement				
Investment Dividends				
Other:___________________				

Monthly Expense for Household: $_________________

Type of Expense	**Total**
Mortgage/Rent	
Transportation	
Child Support/Alimony	
Utilities (water/gas/electric/propane)	
Telephone (land line and cell phone)	
Cable (including internet)	
Miscellaneous Expense (necessities)	
Groceries	
Other: Please list Credit Cards, Loans Or other monthly installments	
1.______________________________ 2.______________________________ 3.______________________________ 4.______________________________	

Assets: Please list all assets for your household

Total Assets for household: $_______________

Type of Asset	**Y**	**N**	**Value**
Housing(Property owned)			
Checking/Savings Name and Location:			
Vehicles 1.Year: Make: Model: 2.Year: Make: Model 3.Year: Make: Model:			
Recreational 1. 2. 3.			
Investments: 1. 2. 3.			
Other:			
Other:			
Other:			

Have all other resources been exhausted? This includes Private, State, and Federal programs

_____NO _____Yes: If yes, please indicate which programs, dates of application, and copies of acceptance or denial letters

____

____

Additional Information

Please explain if you expect a change in income, health, other circumstances, or cannot provide the requested information. Explain also, any special or extenuating, (unusual), circumstances:

____

____

____

The signature on this form certifies that the information provided is true and accurate to the best of my (our) knowledge. As an applicant for Financial Assistance, I understand the following: Community Memorial Hospital and its agents may verify the information provided in this application. Verification can include, but is not limited to, the inquiry of my (our) credit history through a credit reporting agency. Any information proven to be untrue, the organization will re-evaluate my (our) financial status and take whatever action it deems appropriate. If the approval is for less than the total amount owed, monthly payment arrangements must be made within 30 days of approval. If monthly payments are not made for the remaining balance after adjustment, the accounts will be forwarded to a collection agency. This application is only valid for accounts that are in a current status with CMH and for dates of service through the signed date of this application. Additional dates of service may require a new application.

____

Signature **Printed Name** **Date**

____

Signature **Printed Name** **Date**

CMH
Charity Care Annual Income Guidelines

Proposed Discount	100 %	80%	60%	40%	20%
Size of Family Unit	100 %-110% Of Poverty	111%-125% Of Poverty	126%-150% Of Poverty	151%-175% Of Poverty	176 %-200% Of Poverty
1	10830-11913	11914-13537	13538-16245	16246-18952	18953-21660
2	14570-16027	16028-18212	18213-21855	21856-25497	25498-29140
3	18310-20141	20142-22887	22888-27465	27466-30242	32043-36620
4	22050-24255	24256-27562	27563-33075	33076-38587	38588-44100
5	25790-28369	28370-32237	32238-38685	38686-45132	45133-51580
6	29530-32483	32484-36912	36913-44295	44296-51677	51678-59060
7	33270-36597	36598-41587	41588-49905	49906-58222	58223-66540
8	37010-40711	40712-46262	46263-55515	55516-64767	64768-74020

For family units with more than 8 members, add $3740 for each additional person at 100% of poverty

THE 2009 HHS POVERTY GUIDELINES

http://aspe.hhs.gov/POVERTY/09poverty.shtml

February, 2009