CUBA MEMORIAL HOSPITAL
CHARITY CARE PROGRAM

Dear Patient:

Cuba Memorial Hospital has designed a Charity Care program to help New York State residents without medical insurance with their medical costs.

The patient must meet certain income guidelines and must also have exhausted all means of obtaining third party insurance coverage.

Depending on your income level, your cost for services could be free, (see Charity Care table I), or you could be charged a reduced rate (see Charity Care table II).

If approved for either program, the coverage is valid for one year from the date on your application. Specific services that are not included under these programs are those services not performed by Cuba Memorial Hospital, such as Physician fees and laboratory work, which is provided by ACM Labs.

In order to complete this process, you must also have exhausted all other means of obtaining insurance coverage, including Medicaid and Child Health Plus. You must provide denials for Medicaid and Child Health Plus (for your children, if applicable) along with your completed application. Your Medicaid denial must be for income reasons only, not for procedural reasons. You must also submit proof of your income; We require a copy of your most recent pay stub or your unemployment schedule and a copy of your previous year's income tax return. **Our policy states, once you are approved we can only go back 240 days for services prior to date application received.**

The Charity Care program is NOT an insurance coverage. If approved by Cuba Memorial Hospital, it is only valid for services provided by Cuba Memorial Hospital. You must apply at other facilities in order to be covered elsewhere; not all organizations have these programs.

Charity Care follows the Medicaid guidelines for frequency and limitation for services.

If you would like to apply for the Cuba Memorial Charity Care program, please fill out the attached application and mail it to the address at the top of the application with supporting documents.

1. Your most recent pay stub or unemployment schedule.
2. Medicaid denial (cannot be for procedural reasons) (if applicable).
3. Child Health Plus denial (if applicable).
4. Copy of previous year's income tax return.

If you have any questions regarding what information is required, please call (585) 968-3877 extension 226.

We thank you for choosing Cuba Memorial Hospital for your healthcare needs; we are confident you will be happy with the services you will receive at our facility.

Sincerely,

John T. Ormond

John T. Ormond
Chief Financial Officer

CUBA MEMORIAL HOSPITAL
140 WEST MAIN STREET, CUBA, NY 14727
Attn: Accounting Office
585-968-3877 x226

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR CHARITY CARE

I hereby request that CUBA MEMORIAL HOSPITAL make a written determination of my eligibility for the Charity Care program. I understand that the information which I submit concerning my annual income and family size is subject to verification by CUBA MEMORIAL HOSPITAL. I also understand that if the information which I submit is determined to be false or in excess of established guidelines, a determination will result in a denial of services as uncompensated or at reduced fees, and that I will be liable for the charges for services provided.

Date of Request _____

Name _____ Phone Number _____

Address _____

Occupation: Husband _____ Employer _____
Wife _____ Employer _____

Income: Please list all family income:	**Total for Last 3 Months**	**Total for Prior Year**
Wages		
Farm or Self-Employment		
Public Assistance		
Social Security		
Unemployment Compensation		
Workmen's Compensation		
Strike Benefits		
Alimony/Child Support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest & Rents		

You must attach a copy of your most recent pay stub.

Family Size:

Name:	Relationship:	Insurance:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Type of Service Required: _____

I affirm that the information provided above is true and correct to the best of my knowledge. I understand that the Hospital may condition the provision of uncompensated or reduced fee services on my applying for benefits under other programs such as Medicaid.

_____ _____
Date Signature of person making request

CUBA MEMORIAL HOSPITAL CHARITY CARE PROGRAM
SCHEDULE OF INCOME GUIDELINES
Table I

This following table is to be used for Category A & B patients.

Size of family unit	Income Guideline
1	$29,700
2	$40,050
3	$50,400
4	$60,750
5	$71,100
6	$81,450
7	$91,850
8	$102,250

For each additional family member add $4,150 to the income guideline table. Your gross family income must be at or below the above levels to be eligible to receive free care under the Charity Care Program. The above table determines eligibility for all states except Alaska and Hawaii.

NOTICE: MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

This health care facility may not deny emergency services to any person who cannot afford to pay for their medical care.

If you are not able to pay for all or part of the care you need, please contact the Admissions or Business Office of this facility and ask about availability of such care.

CUBA MEMORIAL HOSPITAL CHARITY CARE PROGRAM
SCHEDULE OF INCOME GUIDELINES
Table II

This following table is to be used for both Category A & B patients.

Size of family unit	Income Guideline
1	$ 35,640
2	$ 48,060
3	$ 60,480
4	$ 72,900
5	$ 85,320
6	$ 97,740
7	$110,190
8	$122,670

For each additional family member, add $12,400 to the income guideline table. Your gross ***family*** income must be at or below the above levels to be eligible to receive discounted care under the Cuba Memorial Hospital Charity Care program.