CAYUGA HEALTH SYSTEM FINANCIAL ASSISTANCE PROGRAM
NOTICE TO APPLICANT

Thank you for your interest in the Cayuga Health System Assistance Program.

Eligibility Requirements:

1. In most cases, applicants must apply for and be denied by Medicaid.

2. Applicant must not be claimed as a dependent on family member's income taxes. If the applicant is claimed as a dependent, we need to have all household residents name and date of birth including the Head of Household, which appears on the income tax return. We will include all residents' income within the tax return to determine the applicants' eligibility for the Discount Program.

3. Applicants must meet certain income guidelines. Please refer to the current Cayuga Health System Sliding Fee Scale Discount Guidelines matrix sheet. The level of discount is dependent upon income.

4. Applications will not be reviewed until all required documentation is submitted.

5. A determination of eligibility shall be made within thirty (30) business days of your submission of a completed application that accompanies all required documentation. Missing documentation will delay determination of eligibility.

6. Verification of income:

- Proof of income for the last three (3) consecutive months (we multiply this by four to determine an average income for 12 months). **OR**
- Proof of income for the last 12 months. **OR**
- If there is no income, you must submit a letter stating that neither you, nor anyone listed on the Cayuga Health System Financial Assistance Program Application, has any income.

Income proof includes: Wages (check stubs must indicate dates and employer), Social Security Benefit Notices, Disability Statements, Compensation Statements, Interest, Dividends, Rental Income, Pension, VA benefits, Unemployment benefits, Child support, Alimony. Submitted proof of income should equal the amount indicated in the "Annual Income" box of the Cayuga Health System Financial Assistance Application.

7. Applicants are required to contact the Financial Counselors if income levels change by $5,000 or more, or if medical insurance is acquired. Failure to comply with this may result in increased liability on previously adjusted accounts.

Cayuga HEALTH SYSTEM

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Patient Sticker

Date: _____

Patient's Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Date(s) of Medical Care: _____

Location of Medical Care: ☐ CMC ☐ CMA ☐ Schuyler

Health Insurance Company: _____

Employer (self): _____ (spouse): _____

Can you be named as a dependent by anyone else? ☐ Yes ☐ No
If yes, you must include income information on that person and all dependents of that person.

List total number of dependents in your household as defined by the I.R.S.

Dependent Information: (attach extra sheet as necessary)	
Name:	**DOB:**
Name:	**DOB:**
Name:	**DOB:**
Name:	**DOB:**

Status of Applications:

Medicaid:	☐ have not applied	☐ pending	☐ denied (attach copy)
Child Health Plus:	☐ have not applied	☐ pending	☐ denied (attach copy)
Other Governmental Plans:	☐ have not applied	☐ pending	☐ denied (attach copy)

Monthly Income: (please include all income from all individuals in your household)

Monthly GROSS Household Income:	$ _____	Please attach pay stubs for the most recent 3 month period.
Monthly Interest / Dividends:	$ _____	Please provide copies of most recent statements
Monthly Child Support / Alimony:	$ _____	Please provide supporting documentation
Monthly Pension / Social Security:	$ _____	Please provide copies of most recent statements
Monthly Rental / Other Income:	$ _____	Please provide supporting documentation

I affirm by my signature below that the information contained in this applications is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility. I agree to promptly inform Cayuga Health System of any changes in my needs, address, or a change in my income of $5,000 or more. I agree to allow Cayuga Health System to use the information on this application to determine my financial assistance eligibility at all participating providers.

Applicant's Signature: _____ **Relationship:** _____

Mail Completed Application to your location of Medical Care:

Cayuga Medical Center
Patient Accounting
Attn: Financial Assistance
201 Dates Drive
Ithaca, New York 14850
(469) 322-4990

Cayuga Medical Associates
Attn: Financial Aid
1301 Trumansburg, Rd
Suite P
Ithaca, New York 14850
(607) 882-0010

Schuyler Hospital
Attn: Financial Counselor
220 Steuben Street
Montour Falls, New York 14865
(607) 535-8671 or (607) 535-8600

For use by Cayuga Health System ONLY: ☐ **CMC** ☐ **Schulyer** ☐ **CMA**
☐ Approved at _____% ☐ Denied ☐ Pended Date: _____
If Initially pended: Final Determination Approved at _____% ☐ Denied

Appendix B
Cayuga Health System Financial Assistance Matrix
2016 Guidelines (Uninsured & Underinsured)

Family Size, Income Levels, & Sliding Discount Schedule

2016 Federal Poverty Guidelines:
Released 1/26/2016 - Update annually

Source: http://aspe.hhs.gov/poverty-guidelines

Note: HHS Poverty Guidelines need to be update by Feb. 1st with the most recent year's guidelines

Discount	Nominal Fee	90%	80%	70%	60%	50%	40%
Upper Limit of % of Federal Poverty Level	100%	125%	150%	175%	200%	250%	300%
	100% or Below	101-125%	126 - 150%	151-175%	176-200%	201-250%	251 - 300%
1	$ 11,880.00	$ 14,850.00	$ 17,820.00	$ 20,790.00	$ 23,760.00	$ 29,700.00	$ 35,640.00
2	$ 16,020.00	$ 20,025.00	$ 24,030.00	$ 28,035.00	$ 32,040.00	$ 40,050.00	$ 48,060.00
3	$ 20,160.00	$ 25,200.00	$ 30,240.00	$ 35,280.00	$ 40,320.00	$ 50,400.00	$ 60,480.00
4	$ 24,300.00	$ 30,375.00	$ 36,450.00	$ 42,525.00	$ 48,600.00	$ 60,750.00	$ 72,900.00
5	$ 28,440.00	$ 35,550.00	$ 42,660.00	$ 49,770.00	$ 56,880.00	$ 71,100.00	$ 85,320.00
6	$ 32,580.00	$ 40,725.00	$ 48,870.00	$ 57,015.00	$ 65,160.00	$ 81,450.00	$ 97,740.00
7	$ 36,730.00	$ 45,912.50	$ 55,095.00	$ 64,277.50	$ 73,460.00	$ 91,825.00	$ 110,190.00
8	$ 40,890.00	$ 51,112.50	$ 61,335.00	$ 71,557.50	$ 81,780.00	$ 102,225.00	$ 122,670.00
For each additional person, add	$ 4,160.00	$ 5,200.00	$ 6,240.00	$ 7,280.00	$ 8,320.00	$ 10,400.00	$ 12,480.00

Nominal Fee Schedule

If the patient has an annual income **at or below 100% of the poverty level, a nominal payment applies (see below). The rest of the bill will be written off.

Inpatient Services	$150/Discharge
Ambulatory Surgery	$150/Discharge
MRI Testing	$150/Discharge
Adult ED/Clinic Services	$15/Visit
Prenatal & Pediatric Clinic Services	Not Specified
Ancillary Services	No Charge