MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL ASSISTANCE PROGRAM

Before completing the form, have you applied for Financial Assistance at another Munson Healthcare facility within the last 12 months? If so, you may <u>not</u> need to complete this application.

Under its assistance program Munson Healthcare Otsego Memorial Hospital will make available a reasonable amount of uncompensated or reduced-price services to persons eligible under applicable guidelines. Munson Healthcare Otsego Memorial Hospital Assistance Program services are not limited to any specific hospital service. Individual eligibility for assistance is determined by measuring family income in relation to family size against the income poverty level established by the Community Service Administration. The current income requirements for assistance are listed below:

Household Size	UP TO 200% FPL 100% DISCOUNT	201% - 300% FPL 75% DISCOUNT	301% - 400% FPL 65% DISCOUNT
	Annual	Annual	Annual
1	$27,180.00	$40,770.00	$54,360.00
2	$36,620.00	$54,930.00	$73,240.00
3	$46,060.00	$69,090.00	$92,120.00
4	$55,500.00	$83,250.00	$111,000.00
5	$64,940.00	$97,410.00	$129,880.00
6	$74,380.00	$111,570.00	$148,760.00
7	$83,820.00	$125,730.00	$167,640.00
8	$93,260.00	$139,890.00	$186,520.00
Each Add'l Person Add	$9,440.00	$14,160.00	$18,880.00

If you think you may be eligible for assistance, you should return the enclosed form with all required documentation or contact the Financial Assistance Specialist at 231-935-2350 during normal business hours, Monday thru Friday between the hours of 8:00 a.m. and 4:30 p.m.

A determination will be made within 30 days receipt if all pertinent information is returned with the application. The following documents are required:

***SSA 1099 (Social Security proof)**
***Pension Proof**
***Unemployment Proof**
***Child Support/Spousal Support**
***Complete Federal Tax Return & Schedules**
***All W-2's (Federal)**
***Four (4) most recent pay stubs.**

<u>Current FA is good till 3/10/22</u>

Munson Healthcare Otsego Memorial Hospital
Financial Assistance Application

Deadline for receipt of Financial Assistance Application for services – The later of: 30 days after the date written notice of financial assistance is provided, or 240 days after the first post-discharge billing statement for previous care. Application and requested documentation must be returned within 14 calendar days.

I. RESPONSIBLE PARTY				**SSN** _____
LAST NAME	FIRST NAME	MI	MARITAL STATUS	DATE OF BIRTH
STREET ADDRESS			PO BOX	
CITY	STATE	ZIP	HOW LONG AT THIS ADDRESS?	HOME PHONE
ARE YOU EMPLOYED? ____ YES ____NO	____FULL-TIME	____PART-TIME	____SEASONAL	
EMPLOYER NAME AND ADDRESS				YEARS EMPLOYED _____
DO YOU FILE TAXES? _____ YES _____ NO	ARE YOU *RECEIVING* OR HAVE YOU *APPLIED* FOR SOCIAL **SECURITY DISABILITY** PAYMENTS?			

II. SPOUSE OR SIGNIFICANT OTHER			**SSN** _____
NAME			DATE OF BIRTH
ARE YOU EMPLOYED? ____ YES ____NO	____FULL-TIME	____PART-TIME	____SEASONAL
EMPLOYER'S NAME AND ADDRESS			YEARS EMPLOYED _____
DO YOU FILE TAXES _____ YES _____NO	ARE YOU *RECEIVING* OR HAVE YOU *APPLIED* FOR SOCIAL **SECURITY DISABILITY** PAYMENTS?		

III. HOUSEHOLD INFORMATION (ALL OTHER PERSONS IN HOUSEHOLD)		
NAME	DOB	RELATIONSHIP
TOTAL PERSONS IN HOUSEHOLD:		

IV. MONTHLY INCOME		
RESPONSIBLE PARTY'S MONTHLY INCOME		$
SPOUSE/SIGNIFICANT OTHER'S MONTHLY INCOME	+	$
TOTAL MONTHLY INCOME:	**=**	**$**

Fill this out and send it back to prevent any more medical bills from going to bad debt.

V. HAVE YOU BEEN APPROVED FOR MEDICAID?	Yes _____ NO_____
FILL IN SPENDDOWN AMOUNT IF APPLICABLE	APPROVED SPENDDOWN AMOUNT _____

VI. MISCELLANEOUS INCOME PER MONTH – complete All fields with gross monthly amount or N/A if not applicable			
DIVIDENDS, INTEREST	$	PENSIONS	$
SOCIAL SECURITY	$	INVESTMENT/RENTAL INCOME	$
UNEMPLOYMENT/WORKER'S COMPENSATION	$	GRANTS	$
CHILD SUPPORT/ALIMONY	$	Other	$
TOTAL MONTHLY MISCELLANEOUS INCOME:	$		
MONTHLY INCOME:	+		$
TOTAL MONTHLY INCOME:	**= $**	**ANNUAL:**	**$**

ALL INCOMPLETE OR FRAUDULENT APPLICATIONS WILL BE DENIED AND FOLLOW THE PROCEDURE GUIDELINES DEFINED IN THE FINANCIAL ASSISTANCE POLICY

YOU ARE REQUIRED TO NOTIFY MUNSON OMH OF ANY INCOME CHANGES DURING YOUR APPROVAL PERIOD

IN COMPLETING THIS FINANCIAL STATEMENT, I HEREBY AFFIRM THAT THE ABOVE STATEMENTS ARE CORRECT AND COMPLETE, AND I GIVE MY CONSENT TO FURTHER VERIFICATION BY MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL OR ITS AGENTS.

SIGNATURE/ DATE: _____/_____

RELATIONSHIP IF OTHER THAN PATIENT: _____

FOR OFFICE USE ONLY

APPROVED/DENIED	%	$	DATE:
APPROVED BY:			

Approved applications will be effective for services covered according to Financial Assistance Policy guidelines for up to one (1) year from the approval date.

The following documents are required (if applicable):

***SSA 1099 (Social Security proof)**
***Pension Proof**
***Unemployment Proof**
***Child Support/Spousal Support**
***Complete Federal Tax Return & Schedules**
***All W-2's (Federal)**
***Four (4) most recent pay stubs.**