Application for Hospital Financial Assistance
Solicitud de asistencia económica del hospital
(Completed application must be submitted within 20 working days with proof of income.)

Name/ Nombre:	Street Address/ Calle/Direction:	City, State, Zip Estato Pueble:	
Soc Sec #: *Seguridad social*:	Phone (home/cell) Telephono de Casa	Phone (work) Telephono de Tabajo:	
Hospital Acct#	Balance $	Hospital Acc #	Balance $

Have you applied for Medicaid? ________Yes No_______ If no, why not? _____________________
Ha solicitado Medicaid? _________ Si No_______ Si no, porque?_______________________

Briefly describe your financial situation: ____
Describa brevemente su situación económica

DEPENDENTS/ *PERSONAS A SU CARGO:*

Name/ *Nombre*	**Age**/ *Edad*	**Relationship**/ *Parentesco*

ANNUAL INCOME/ *INGRESO ANUAL*:

Patient Income/ Ingreso del paciente:	**Spouse Income**/ Ingreso del cónyuge:	**Other Family Member's Income/** Ingreso de otros miembros de la familia**:**
Social Security/ *Seguridad social*:	**Pension**/ *Pensión*:	**VA Benefits**/ *Beneficios para veteranos*:
Alimony/ *Pensión alimenticia*:	**Child Support**/ *Sostén por niño*:	**Public Assistance**/ *Asistencia pública*:
Unemployment/ *Desempleo*:	**Compensation**/ *Compensación*:	**Other**/ *Otros*:

NOTE: Federal income tax return, and last two pay stubs must be enclosed with this application to document patient and family income. If Social Security is your **only** ***income, submit a copy of the Social Security statement, copy of the Social Security check or a copy of your bank statement showing direct deposit of Social Security payment.*** I certify that the above information is true and accurate to the best of my knowledge. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and require full and immediate payment of this debt.

I give my permission to Health Alliance of the Hudson Valley to disclose this information to any Federal or State agency responsible for determining program compliance.

NOTA: El reembolso del impuesto federal a las ganancias y los dos últimos talones de pago deben adjuntarse a esta solicitud para documentar los ingresos del paciente y la familia. Si la Seguridad Social es su **único** ***ingreso, presente una copia del informe de Seguridad Social, copia del cheque de Seguridad Social o una copia del informe de su banco donde se muestra el depósito directo del pago de Seguridad Social.***
Certifico que la información antes mencionada es fiel y verdadera según mi mejor conocimiento. Si la información suministrada fuese falsa, comprendo que el hospital puede reevaluar mi situación económica y solicitar el pago inmediato y completo de esta deuda.

Doy mi autorización a Health Alliance de Hudson Valley a mostrar esta información a cualquier agencia federal o estatal responsable de determinar el cumplimiento del programa.

______________________________ ____________________________________
Date of Request Applicant's Signature
Fecha de solicitud Firma del solicitante

INDIVIDUAL NOTICE OF AVAILABILITY OF FINANCIAL ASSISTANCE 2016

Health Alliance of the Hudson Valley provides a reasonable amount of its services at a reduced charge or no charge to eligible persons who request those services. Financial Assistance will be available to persons whose family income is not greater than the Federal Poverty Income Guidelines listed below, and applies to hospital bills only. Private physician fees are not covered under this program.

	% of Income			
Family Size	HHS Poverty Income $	150%	250%	300%
1	11,880.00	17,820.00	29,700.00	35,640.00
2	16,020.00	24,030.00	40,050.00	48,060.00
3	20,160.00	30,240.00	50,400.00	60,480.00
4	24,300.00	36,450.00	60,750.00	72,900.00
5	28,440.00	42,660.00	71,100.00	85,320.00
6	32,580.00	48,870.00	81,450.00	97,740.00
7	36,730.00	55,095.00	91,825.00	110,190.00
8	40,890.00	61,335.00	102,225.00	122,670.00
% of Discount	**100%**	**80%**	**50%**	**25%**

***For families with more than eight members, add $4,160. for each additional member.

If you think you may be eligible, please complete this application and send with proof of income, such as **your most recent Federal Tax return,** last **4 pay stubs, or other documents** to:

Health Alliance of the Hudson Valley
Attention: Patient Accounting Dept.
741 Grant Ave.
Lake Katrine NY 12449

A written conditional or final determination of your eligibility will be made within 30 days following receipt of the application. Questions should be directed to 845-334-2743. Once you have submitted this application, please disregard any bills until you receive our response.