Financial Assistance Program

Champlain Valley Physicians Hospital
75 Beekman St., PO Box 2868 Plattsburgh, New York 12901
518-562-7074
Fax: 518-314-3981
patientaccounting@cvph.org

Dear Applicant,

Thank you for choosing Champlain Valley Physicians Hospital as your health care provider.

If payment of your medical bills creates a financial hardship for you, you may be eligible for financial assistance through Champlain Valley Physicians Hospital's Financial Assistance Program. Our staff are here to help you and are willing to work through the process with you. Please note that before any financial assistance can be provided by Champlain Valley Physicians Hospital, our staff will work with you to identify other sources of payment.

The following criteria must be met to be eligible for financial assistance from Champlain Valley Physicians Hospital:

- You must be a permanent resident within the Champlain Valley Physicians Hospital financial eligibility area which includes Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, and Washington counties of New York.
- The services that were provided to you must be considered medically necessary essential health care services.
- The following types of services are not eligible for financial assistance:
  - Cosmetic services - unless medically necessary based upon diagnosis with physician review.
  - Birth control, infertility treatments, fertility services, sterilization and reversal of sterilization.
  - Services that have been placed in Collections beyond 120 days of placement.
  - General dentistry unless extenuating circumstances are presented by the dental practice.
  - Services to residents outside of the financial eligibility area unless provided in an emergency room setting.
  - Services reimbursed directly to you by your insurance carrier or already covered by another third party.
- Household income and assets/resources must be within income and asset guidelines.

If you meet the criteria and wish to apply for the Champlain Valley Physicians Hospital Financial Assistance Program, please complete the enclosed application form. Please note, you will continue to be financially responsible for all services you receive until it is determined you qualify for assistance.
We are here to help, if you have any questions or require aid in understanding any part of the application process please contact a member of our Customer Service team at 518-562-7074 or contact us by email at: patientaccounting@cvph.org. For help in completing the application, a Financial Advocate is available M-F, 8:00am-4:00 pm at the CVPH main campus, Patient Registration Lab area 75 Beekman St, Plattsburgh, NY 12901. Completed applications should be forwarded to the following address:

Champlain Valley Physicians Hospital
Financial Assistance Program
75 Beekman St.
PO Box 2868
Plattsburgh, New York 12901

For Your Convenience - Our Documentation Check List

To determine if you qualify for assistance, you will need to show proof of your income, and also supply documentation necessary for determination. Please fill out the attached application in full, sign it, and send the application along with a copy of each of the following documentation (those that are applicable) for your household:

Note: If sending Bank Statement or Online documentation, copies must include the bank name, client name, balance and current date.

1.) Optional: Complete copy of your most recent Federal Income Tax Return and all schedules and forms, (e.g. 1040, 1040A, 1040 EZ, etc., 1099 etc. ☐

2.) Self-employed/Sole Proprietor must provide complete documentation of the following:

- a.) Optional: Federal Tax Returns and Year to Date Profit and Loss statement ☐
- b.) Optional: Partnership: All of the above, plus Partnership Federal Tax Return ☐
- c.) Optional: Corporation: All of the above, plus Corporation Federal Tax Return ☐

3.) Copies of the two (2) most recent, consecutive paycheck stubs or a statement from the employer ☐

4.) Copy of one (1) most recent bank statement, (e.g., savings, checking, money market, etc.) ☐

5.) Copy of unemployment benefits statement if applicable (e.g., check, bank statement, online, etc.) ☐

6.) Copy of disability compensation benefit statement/award letter (e.g., check, bank statement, online, etc.) ☐

7.) Copy of social security, pension, retirement income (e.g., award letter, check stub, bank statement, etc.) ☐

8.) Documentation of child support and/or alimony paid or received (e.g., cancelled check, garnishment, bank statement, etc.) ☐

9.) Investment accounts - copies of current or quarterly statement from broker or financial institution (Excludes Retirement Accounts) ☐

10.) Real Estate - tax assessment or tax bill, and mortgage balance statement on property owned, excluding primary residence ☐

11.) Rental Income - Copy of current Schedule E of IRS form ☐

12.) Appraisal for recreational vehicle from www.nadaguides.com and bank loan statement if applicable ☐

13.) If an application for state assistance, (e.g. Medicaid, State Health Exchange) has been made in the last 60 days, please provide a copy of application ☐

14.) If proof of residency is required, please send one of the following: NY driver's license, property tax bill, lease for property, or a utility bill ☐

15.) Other: ____ ☐

Please use the above checklist to be sure we have all the information we need to quickly and correctly process your application. It is important that your application be complete, and that all necessary documentation is received. All information you provide to us is confidential.

Questions & Answers and Information You Should Know...

Can I get help completing my application?

Yes. Please contact Customer Service at (518) 562-7074 with questions, or email us at patientaccounting@cvph.org. If you would like to speak to a representative in person our Financial Service Office is located at the Main Campus, CVPH, First floor, 75 Beekman St, Plattsburgh, NY 12901.

If a question or section does not pertain to me, can it be left blank?

No. We cannot assume an unanswered question or section means it does not apply to you. One of the requirements when applying for financial assistance with Champlain Valley Physicians Hospital is a complete application. If a section or question does not apply, write "N/A" for not applicable.

I don't have all the documentation requested but the application is due back. Can I send what I have?

No. You must return a complete application with all the appropriate documentation applicable or the application will be returned as denied. Extension will only be made on a case by case basis for extenuating circumstances and must be requested by contacting Customer Service or the Financial Program Specialist at (518) 562-7074.

What is a tax assessment?

This is the tax bill you get yearly from your town clerk or City Hall office. It will say "Tax Bill" or "Property Tax Bill" at the top of the page. It gives the current house site value, house site municipal tax and house site education tax values.

Where do I get the "book" value or loan value for my recreational vehicle?

If you have access to a computer and the Internet, you may go online to look up the year, make and model for an estimate at www.nadaguides.com. If you do not have access to a computer contact a local dealer. Please provide written documentation.

Why was the verification I sent for my bank account(s) not accepted?

We require a copy of the original bank statement(s). If this is not available we will only accept a substitute statement which has the following: bank name, client name, type of account, current date, and current balance. Each of these items must be printed on bank letterhead and not hand written.

What is a benefit award letter?

If you are receiving social security or disability benefits, this is the yearly letter that social security sends notifying you of your monthly eligible benefits. For verification purposes we will accept a copy of the benefit award letter, a copy of your social security (disability) check or if you have direct deposit we will accept your bank statement showing your social security deposit as verification. Whichever verification is used, the monthly eligibility benefits should match the amount given on the application.

Questions & Answers and Information You Should Know..., continued

My employer does not provide pay stubs, what should I do?

If pay stubs are not provided by your employer, an affidavit on letterhead from the company you work for will be accepted. The affidavit must show gross pay, deductions, and net pay for one month. Please note, if you are married or have a civil union partner, his / her verification is also required.

What is the coverage period for Financial Assistance?

Financial Assistance is valid for up to six months and may include coverage to current balances unless otherwise noted. Your coverage period will be indicated on your grant letter. If your income indicates you may be eligible for Medicaid, NY Family Health Plus or another insurance program funded by the State, you will only be granted financial assistance for current charges until a Medicaid application is made and received by the Financial Assistance Program Specialist.

How often do I need to re-apply for financial assistance?

The Financial Assistance Program at Champlain Valley Physicians Hospital is not an insurance company or a program such as Medicaid, or NY Family Health Plus. We are here to assist patients who face financial hardship and are unable to pay their bills. Financial Assistance should only be applied for if you have outstanding Champlain Valley Physicians Hospital medical bills you cannot pay, expectation that an account currently pending insurance will leave a balance, or expectation that a future scheduled service will leave you a balance.

Financial Assistance Application

Applicant's Information:

Applicant Last Name	First Name	Middle Initial	Social Security Number (optional)	Date of Birth

Address	City	State	Zip code	Home Phone Number	Medical Record #

Employer or check one: ☐student ☐unemployed ☐disabled ☐retired

Marital Status - please check one: ☐single ☐married ☐separated ☐divorced ☐widowed

Spouse Last Name	Spouse First Name	Middle Initial	Social Security Number (optional)	Date of Birth

Spouse Employer or check one: ☐student ☐unemployed ☐disabled ☐retired

Household Information:

Please list below all dependents who live in your household.
It is not necessary to include non dependents who reside in your household.
Note: You may include dependents for which you provide at least 50 % support and who are reflected as dependents on your Federal Income Tax Returns.

Last Name	First Name	Social Security # (optional)	Relation to Applicant	Date of Birth

Monthly Expenses:

Rent Payment $ ____________________ OR Mortgage Loan Payment $ ______________________________

Property Tax Amount Not Included in Payment Amount Above: $ ____________________

Do You Own Property Other Than Primary Residence? ☐ Yes ☐ No If Yes, Monthly Loan Payment: $ __________________

Utilities	$ __________	Credit Card	$ __________	Insurance (Auto/Life/Property)	$ __________
Auto	$ __________	Health Insurance	$ __________	Alimony/Child Support	$ __________
Child Care	$ __________	Healthcare Bills	$ __________	Other: __________________	$ __________
Living (food/gas)	$ __________	Medications	$ __________	Other: __________________	$ __________

Extenuating Expense Circumstances: ____

Additional Information:

Are you covered under any health insurance policy? ☐Yes ☐No

If yes, list insurance(s): ____

Are you seeking financial assistance for services resulting from any of the following: ☐Yes ☐No

☐ Work Related ☐ Liability ☐ Motor Vehicle

Do you have an application pending for insurance on the Health Exchange or State Aid such as Medicaid, or NY Family Health Plus? ☐Yes ☐No

Did you file and/or are you required to file a Federal Tax return? You may wish to provide copies of your current Federal Income Tax Returns. (optional) ☐Yes ☐No

If no, why? ____

Do you reside in New York greater than 6 months per year? ☐Yes ☐No

Do you have outstanding balances with any of The UVM Health Network partners?

☐ EMT of CVPH ☐Yes ☐No

☐ Alice Hyde Medical Center ☐ Central Vermont Medical Center
☐ Elizabethtown Hospital ☐ University of Vermont Medical Center ☐Yes ☐No

Assets and Income

REAL ESTATE owned other than primary residence. Please check those that apply, or check 'Not applicable'

Note: Tax assessment/tax bill and mortgage balance statement, if applicable. Attach separate list if multiple properties exist.

☐Vacation Home ☐Second Home ☐Land ☐Not applicable Value: $

Location (address): Mortgage Balance: $

☐Rental Property ☐Not applicable Value: $

Location (address): Mortgage Balance: $

RECREATIONAL VEHICLES owned: Please check those that apply, or check 'Not applicable'

☐Boat	Value: $	Loan Balance: $	Not applicable ☐
☐Camper	Value: $	Loan Balance: $	Not applicable ☐
☐ATV / Snowmobile	Value: $	Loan Balance: $	Not applicable ☐
☐All Other Debt		Loan Balance: $	Not applicable ☐

Monthly Income From:	**Person 1**	**Person 2**	
Name of household member:			Documentation required for verification:
Gross Salary Wages	$	$	2 consecutive pay stubs / employer pay statement
Self Employed	$	$	Tax Return plus current YTD Profit & Loss (If applicable/ optional)
Social Security	$	$	Award letter, check stub, bank statement, etc.
Workers' Compensation	$	$	Check, bank statement, online, etc.
Unemployment	$	$	Check, bank statement, online, etc.
Alimony / Child Support	$	$	Cancelled check, garnishment, bank statement, etc.
Pension / Retirement Income	$	$	Bank Statement or Pension check stub
Disability	$	$	Check, bank statement, online, etc.
Rental Income	$	$	Schedule E of IRS tax form
Dividend Income	$	$	Current/quarterly statement from financial institution
Other Income:	$	$	Contact FAP Specialist (518) 562-7074
Total:	**$**	**$**	

Cash, Savings and Investments:			
Checking Account Balances	$	$	Bank statement
Savings	$	$	Bank statement
CD Account Balances	$	$	Copy of statement
Bonds	$	$	Copy of statement or bond
Annuities	$	$	Copy of statement
Money Market	$	$	Copy of statement
Trust Account	$	$	Copy of statement
Stocks	$	$	Copy of statement
Mutual Funds	$	$	Copy of statement
Other - Specify: ____________	$	$	Contact FAP Specialist
Total:	**$**	**$**	

Please Read Carefully

I am requesting financial assistance from Champlain Valley Physicians Hospital. I verify that all information I have provided is accurate and complete. Champlain Valley Physicians Hospital has my permission to pursue verification of pertinent information and exchange information regarding my accounts, application and supporting documentation with its affiliated providers. Any incorrect, incomplete or false information provided may cancel my application for financial assistance. I agree to repay the full financial assistance award if I receive payment of any kind for the medical services covered by this financial assistance application. Champlain Valley Physicians Hospital is authorized to access credit bureau files and reports, now and in the future for collection purposes. All information provided will remain confidential under the provisions of HIPAA federal regulations.

Signature of Patient (or Parent / Guardian if Patient is under 18) Date

Champlain Valley Physicians Hospital has implemented a policy with guidelines to provide assistance based upon a sliding grant scale. Balances after the grant has been applied shall remain the responsibility of the patient and should be paid promptly. Please refer to the policy for full details.

Federal Poverty Level	Less than 200%	201% - 250%	251% - 300%	301% - 350%	351% - 400%	Possibly Assets
Grant Discount	100%	91.5%	83%	74.5%	66%	400% FPLG

Updated 01/12/2023 12-Jan-23

For families with more than 8 dependants increase base level by: $ 5,140

Number of Dependents	% OF Poverty Level	Household Income From:	Household Income To:	Guarantor Share Basis: Charges		Number of Dependents	Household Income From:	Household Income To:	Guarantor Share Basis: Charges
1	100%	$ -	$ 14,580	0%		5	$ -	$ 35,140	0%
1	150%	$ 14,580	$ 21,870	0%		5	$ 35,140	$ 52,710	0%
1	200%	$ 21,870	$ 29,160	0%		5	$ 52,710	$ 70,280	0%
1	250%	$ 29,160	$ 36,450	8.5%		5	$ 70,280	$ 87,850	8.5%
1	300%	$ 36,450	$ 43,740	17%		5	$ 87,850	$ 93,120	17%
1	350%	$ 51,030	$ 51,030	25.5%		5	$ 93,120	$ 108,640	25.5%
1	400%	$ 58,320	$ 58,320	34%		5	$ 108,640	$ 140,560	34%
2	100%	$ -	$ 19,720	0%		6	$ -	$ 40,280	0%
2	150%	$ 19,720	$ 29,580	0%		6	$ 40,280	$ 60,420	0%
2	200%	$ 29,580	$ 39,440	0%		6	$ 60,420	$ 80,560	0%
2	250%	$ 39,440	$ 49,300	8.5%		6	$ 80,560	$ 100,700	8.5%
2	300%	$ 49,300	$ 59,160	17%		6	$ 100,700	$ 120,840	17%
2	350%	$ 59,160	$ 69,020	25.5%		6	$ 120,840	$ 140,980	25.5%
2	400%	$ 69,020	$ 78,880	34%		6	$ 140,980	$ 161,120	34%
3	100%	$ -	$ 24,860	0%		7	$ -	$ 45,420	0%
3	150%	$ 24,860	$ 37,290	0%		7	$ 45,420	$ 68,130	0%
3	200%	$ 37,290	$ 49,720	0%		7	$ 68,130	$ 90,840	0%
3	250%	$ 49,720	$ 62,150	8.5%		7	$ 90,840	$ 113,550	8.5%
3	300%	$ 62,150	$ 74,580	17%		7	$ 113,550	$ 136,260	17%
3	350%	$ 62,150	$ 87,010	25.5%		7	$ 136,260	$ 158,970	25.5%
3	400%	$ 87,010	$ 99,440	34%		7	$ 158,970	$ 181,680	34%
4	100%	$ -	$ 30,000	0%		8	$ -	$ 50,560	0%
4	150%	$ 30,000	$ 45,000	0%		8	$ 50,560	$ 75,840	0%
4	200%	$ 45,000	$ 60,000	0%		8	$ 75,840	$ 101,120	0%
4	250%	$ 60,000	$ 75,000	8.5%		8	$ 101,120	$ 126,400	8.5%
4	300%	$ 75,000	$ 90,000	17%		8	$ 126,400	$ 151,680	17%
4	350%	$ 90,000	$ 105,000	25.5%		8	$ 151,680	$ 176,960	25.5%
4	400%	$ 105,000	$ 120,000	34%		8	$ 176,960	$ 202,240	34%

These guidelines are subject to change at any time. All discounts above require a meeting
with a Champlain Valley Physicians Hospital representative to determine eligibility for governmental programs,
and are contingent upon certain payment terms. This schedule is updated annually based on federal poverty guideline at http://aspe.hhs.gov/poverty.