THE University of Vermont HEALTH NETWORK

Elizabethtown Community Hospital

Financial Assistance Program

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: We can not use bank statements as proof of income. The guidelines listed are the minimum for NYS.

1.) Please complete all three (3) pages of the application ☐

2.) Copies of two (2) consecutive paystubs or a letter from your employer indicating all gross income and deductions. ☐

3.) Self-Employment Federal tax return with schedule c and year to date profit and loss. ☐

4.) Copy of unemployment benefits statement from DOL. ☐

5.) Copy of disability compensation benefit statement/award letter. ☐

6.) Copy of social security award letter. ☐

7.) Copy of pension, retirement income award letter or 1099. ☐

8.) Rental Income 1099 or signed letter attesting monthly income or copy of lease. ☐

9.) If an application for state assistance, (e.g. Medicaid, State Health Exchange) has been made and you have received a decision, please provide a copy. ☐

10.) Federal tax return 1040 for dependents. ☐

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.

If you have any questions, please contact (518)873-3139

NYS Uniform Hospital Financial Assistance Application

You may be eligible for hospital financial assistance to pay your bills if you are uninsured, if your insurance is exhausted, or if you have health insurance but have proof of paid medical expenses totaling more than 10% of your income. Completing this form will start your request for hospital financial assistance. This form is used by all hospitals in New York State.

This application must be printed in the primary[1] languages spoken by patients served by the hospital.

Patient Name (complete information that is applicable)

Patient Name (First, Middle, Last)		
Date of Birth (mm/dd/yyyy)		
Address	Apartment/Unit #	
City	State	Zip
Contact Phone #		
Parent/Guardian or Lawful Representative Name (if patient is a minor child or an incapacitated adult)		
Email Address (if any)		

Family Information:

Please list below all family members in your household. Your household includes yourself, your spouse or domestic partner, and any children or other dependents. For example, this would include everyone listed on the same tax return.

Gross income means your income **before** taxes are deducted.

Gross income can consist of work earnings (wages, salaries, tips, earnings from selfemployment), unearned income (social security, disability, and unemployment benefits), contributions (funds from family or friends), and other sources of income (temporary assistance and supplemental security income).

Full Name	Relationship	Total Gross Income (Current)
	Self	

[1] "Primary languages" includes any language that is used to communicate in at least 5% of patient visits per year, or any language spoken by more than 1% of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems.

The hospital may request you submit documentation as proof of income; examples of documentation might include a pay stub, a letter from your employer if applicable, or Form 1040.

Health Insurance Status

Do you have any form of health insurance, including Medicaid, Medicare, or private insurance through your employer or purchased on your own? ☐ Yes ☐ No

If you answered "No," would you like assistance in applying for any of these programs?

☐ Yes ☐ No

Underinsured patients: people with insurance and high medical expenses. If you have insurance, please provide an estimate of the medical bills you paid in the past 12 months.

$

The hospital may request you submit documentation as proof of paid medical expenses.

Patient/Responsible Party: If not the patient, list the name of the person signing the form and their authority to sign on behalf of the patient (e.g., spouse, parent, legal representative).

I understand that the information I submit may be subject to verification from external sources. I certify that the information is true and complete to the best of my knowledge.

Print Name Relationship to Patient	Date
Signature	

Minimum Eligibility and Guidelines

Application Timeline, Patient Rights, and Confidentiality

- You can apply for financial assistance at any point during the collection process.
- You do not have to make any payment to this hospital until you receive a decision on your application for financial assistance. Hospitals may not forward accounts to collection while your application is pending.
- If you are denied financial assistance, you have the right to appeal. Information on how to do so will be included in the hospital's notice you receive. You may have the right to appeal the amount of your financial assistance. The hospital will include information about how to appeal in their decision letter.
- Hospitals cannot send unpaid bills to a collection agency for at least 180 days after your first bill.
- Hospitals are prohibited from taking legal action, including filing lawsuits, to recover unpaid medical bills for patients below 400% of the federal poverty level. Poverty guidelines can be found here: https://aspe.hhs.gov/topics/poverty-economicmobility/poverty-guidelines
- Any information provided in this application will only be used by the hospital to determine your eligibility for financial assistance and will remain confidential to the extent permitted by law.
- A hospital cannot deny you medically necessary services because you have an outstanding medical bill.
- If you need assistance with this application, please contact the UVM Health Network's financial assistance office at (802)847-8000 or (800) 639-2719.
- If you need additional assistance with this application or help appealing a decision, you can reach out to Community Health Advocates: 888-614-5400.

Eligibility

Nothing limits a hospital's ability to establish patient eligibility for payment discounts at income levels higher than those specified below and/or to provide greater payment discounts for eligible patients than those required by Public Health Law. Additionally, immigration status shall not be an eligibility criterion for the purpose of determining financial assistance.

The following individuals are eligible:

- Low-income individuals without health insurance; or
- underinsured individuals (out-of-pocket medical costs accumulated in the past twelve months that amount to more than ten percent of such individual's gross annual income); or
- those who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges; or
- at the hospital's discretion, individuals who can demonstrate an inability to pay their copay and/or deductible can request a reduced or discounted payment.

Individuals up to 400% of the federal poverty level are eligible for financial assistance.

Federal Poverty Levels (2025)			
Household Size	**200%**	**300%**	**400%**
1 Person	$31,300	$46,950	$62,600
2 Persons	$42,300	$63,450	$84,600
3 Persons	$53,300	$79,950	$106,600
4 Persons	$64,300	$96,450	$128,600
5 Persons	$75,300	$112,950	$150,600
6 Persons	$86,300	$129,450	$172,600
7 Persons	$97,300	$145,950	$194,600

Updated annually: https://aspe.hhs.gov/topics/poverty-economic-mobility/povertyguidelines

Minimum Discount Rates

If you qualify for financial assistance, your charges will be reduced according to your income on a sliding fee scale as follows:

Income Level	Payment
Below 200% FPL	Waive all charges
200% - 300% FPL	Uninsured patients: Sliding scale up to 10% of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 10% of the amount that would have been paid pursuant to such patient's insurance cost sharing.
301% - 400% FPL	Uninsured patients: Sliding scale up to 20% of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 20% of the amount that would have been paid pursuant to such patient's insurance cost sharing.

Hospitals may choose to provide greater discounts for eligible patients and/or offer payment discounts for patients at higher income levels.

Installment Plans

Installment plans are available to patients who are unable to pay the reduced rate all at one time. Monthly payments cannot exceed 5% of your gross monthly income and the rate of interest charged to the patient on the unpaid balance, if any, shall not exceed 2%.

Request for Proof of Household Income

Please include the income information for the patient, their spouse, and any dependents (such as children). For example, this would include everyone on the same tax return (tax filer, spouse, and tax dependents) in the calculation of household income.

The following is a list of documents you can use to prove your income. You do not have to provide all these documents. You can also provide a statement of no household income if you have no income.

You may also provide the Eligibility determination page from the NY State of Health Marketplace. If you have this document, you do not have to provide any other income information listed below to the hospital.

If Household Receives:	**Amount per Month:**	**Applicant May Provide:**
Wages	$	Please provide one Paycheck Stub, or Letter from Employer on company letterhead, signed and dated, or most recently filed income tax return.
Social Security Payment	$	Copy of award letter/certificate, or correspondence from the U.S. Social Security Administration, or annual benefit letter. To request a copy of your Social Security benefit letter, call 1-800-772-1213 or visit www.ssa.gov.
Unemployment Compensation	$	Copy of award letter/certificate, or monthly benefit statement from NYS Department of Labor, or Copy of Direct Payment Card with printout, or Correspondence from the NYS Department of Labor, or Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us).
Disability Payment	$	Copy of award letter/certificate, or correspondence from Social Security Administration, or copy of annual benefit letter. To request a copy of your benefit letter, call 1-800-772-1213 or visit www.ssa.gov.
Workers Compensation	$	Copy of Award Letter or Check stub.
Alimony/Child Support	$	Copy of court order, or 3 months of cashed checks/receipts.
Dividends/Interest	$	Quarterly dividend statements or 1 month statements.
Other	$	Letter stating the amount of non-wage earnings (if any), such as rental income, cash for odd jobs, etc.
No Income	$0	Signed statement of no income.

THE University of Vermont HEALTH NETWORK

Elizabethtown Community Hospital

Policy Summary

Get help paying for health care.

We have a financial assistance program to help you afford the care you need.

What is a financial assistance program?

We offer financial assistance to people who don't have insurance. We also offer assistance to people who have insurance with out-ofpocket costs that they can't afford. It can be used for ongoing care and emergencies. The care must be medically necessary for your health to be approved for assistance.

Who can get financial assistance?

To qualify:

- **Eligibility is based on income**; see application for necessary documentation.
- **You must be a "New York resident**" – this includes students, people who are employed in New York, undocumented immigrants, people who live in New York but do not have stable housing It does not include visitors or travelers unless care is emergent. ○ **Your income must be less than the limit.** There are different income limits for free and low-cost care. See the charts.

Income limits

Find your household size and income on the charts below. For most people, your household size will be the people listed on your taxes. If you make too much money for free care, you might qualify for low-cost care.

Free care

You could get free care (pay $0) if your household income is below 250% of the Federal Poverty Level (FPL). In 2025, your income would need to be less than:

Household Size	Maximum Income
1 person	$39,125
2 people	$52,875
3 people	$66,625
4 people	$80,375
5 people	$94,125
6 people	$107,875
7 people	$121,625
8 people	$135,375

Low-cost care

If your household income is below 400% of the Federal Poverty Level (FPL), you may qualify for a discount. In 2025, your income would need to be less than:

Household Size	Income Maximum
1 person	$62,600
2 people	$84,600
3 people	$106,600
4 people	$128,600
5 people	$150,600
6 people	$172,600
7 people	$194,600
8 people	$216,600

Catastrophic care

Ask us about catastrophic (seriously injured or sick) care if you owe the hospital a lot of money, but your income is too high to qualify for free or low-cost care. This type of assistance is available to patients whose balance is greater than 20% of their annual household income. **We can help you determine if you are eligible.**

More information on the back

Services Covered

- Emergency medical services provided in an emergency room setting
- Urgent services for a condition which, if not promptly treated, would lead to a harmful change in the health status of an individual
- Elective medically necessary services

Services NOT Covered

- Cosmetic/Plastic services
- Infertility/fertility services
- Non-medically necessary care
- Research / Experimental services
- International patient care unless service is provided in an emergency room setting; defined as visitors not residents

How to apply

You can apply before or after you get medical services. If you apply after you get services, you must do this within one year of getting the first bill.

Follow these steps:

1. **Get a free application.**
   - In-person: 8 Williams Street, Elizabethtown, NY 12932
   - Online: Elizabethtown Community Hospital | Billing & Financial Assistance (ech.org)
   - Phone: Call (518) 873-3139
2. **Fill out the application.** DO NOT leave any sections blank. Include supporting documentation as noted on the application.
3. **Give or send us your finished application.**
   - Drop it off at: 8 Williams Street, Elizabethtown, NY 12932
   - Mail it to: UVMHN ECH
     Patient Financial Services
     PO Box 277
     Elizabethtown, NY 12932

What happens next?

You will get a letter from us in the next 30 days. It will say if you are approved, denied, or need to send more information.

If your application is denied, you may appeal the decision. Requests for appeals should be sent to the Patient Financial Assistance in writing within 60 days of the denied request and must include the reason for appeal.

How to get help filling out the application

- **Visit our financial counseling office:** 8 Williams St, Elizabethtown, NY 12932
- **CALL**: (518) 873-3139

Free language support

We offer free help to people who have communication or language needs. We can also help those who need this information in different ways. For interpreters and translation support (518) 873-3139.

More information

Who accepts financial assistance?

Not all providers are covered by our financial assistance policy. See our list here: https://www.ech.org/data/files/ECH-FinancialAssistance-Program You can also ask us about your doctor. **Read the full policy**

This is a plain language summary of our financial assistance policy. Our full policy is here: ECH-Financial-Assistance-Summary-2024.pdf

Non-discrimination

We do not discriminate based on race, color, sex, sexual orientation, gender identity, marital status, religion, ancestry, national origin, citizenship, immigration status, primary language, disability, medical condition, or genetic information.