



FINANCIAL ASSISTANCE PACKET

Rome Memorial Hospital is proud of its not-for-profit mission to provide quality care to all who need it – 24 hours a day, 7 days a week, 365 days a year.

If you are under insured or do not have health insurance and worry that you may not be able to pay in full for your care, we may be able to help. Rome Memorial Hospital provides financial aid to patients based on their income and needs. In addition we may be able to help you get free or low-cost health insurance or work with you to arrange a manageable payment plan.

It is important that you let us know if you will have trouble paying your bill; Federal and State Laws require all hospitals to seek full payment of what they bill patients. This means we may turn unpaid bills over to a collection agency, which could affect your credit status.

For more information, please contact our Financial Assistance Coordinator in our Business Office located at 155 West Dominick Street in Rome at (315) 338-7261. We will treat your questions with confidentiality and courtesy.

APPLICATION PROCEDURE

- If your income level meets Medicaid eligible guidelines, then the hospital policy requires that you apply for Medicaid assistance through your County Department of Social Services.
- Application for financial assistance from the hospital must be made within three (3) months from the date of service or date of Medicaid denial.
- If you are over the Medicaid income guidelines (as described below) or are applying for Medicaid assistance due to excess income, complete the application for financial assistance.
- Provide proof of income (i.e. 1040 tax form, 3 months of pay stubs, SS Statement, etc.)
- Provide most current savings account information.
- You will be informed of the decision within 30 working days of receipt of your completed application.
- Once your completed application is submitted, you can disregard any bills from Rome Memorial Hospital until you receive a written decision.

How do I know if my income qualifies me for Medicaid?

The chart below shows how much income you can receive in a year and still qualify for Medicaid. The income level depends on the number of your family members who live with you.

Yearly Income Effective January 1, 2009	
Number in Family	Yearly Income
1	\$10,830
2	\$14,570
3	\$18,310
4	\$22,050
5	\$25,790
For families with more than 5 members add 3,740 for each additional member.	

YOU MAY RETURN YOUR FINANCIAL ASSISTANCE APPLICATION BY MAIL OR IN PERSON TO:

**ROME MEMORIAL HOSPITAL
 BUSINESS OFFICE
 155 West Dominick Street
 Rome, New York 13440**

ANY QUESTIONS MAY BE DIRECTED TO THE BUSINESS OFFICE AT 338-7261.

155 West Dominick Street, Rome, New York 13440 • (315) 338-7261

ROME MEMORIAL HOSPITAL

1500 North James Street, Rome, New York 13440

APPLICATION/DETERMINATION

Name: Last	First	M.I.	D.O.B.

Spouse's Name: Last	First	M.I.	D.O.B.

Address: Street	City/State	Zip Code

Social Security Number	Home Phone	Employer

	Amount	Family Size		
Your Gross Income		<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
Spouse's Gross Income		<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
Other Income: ie; rental, child support, alimony, etc...		<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
Total Family Income		<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly

List Family Members	Age	Relationship	List Family Members	Age	Relationship

Date(s) of Service:

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Circumstances requiring this application (This section must be completed): _____

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Date of Request: _____ Applicant's Signature: _____

ELIGIBILITY DETERMINATION (For Office Use Only)

Date Application Received: _____ Income Verified: Yes No Type: _____

The Applicant is Approved: _____

Amount provided as uncompensated services is: _____

Conditionally Approved: _____

The applicant's request for free or reduced charge services has been denied for the following reason (s): _____

Date of Final Determination: _____ Approved by: _____