Lewis County
Health System
Your Health Partner

Patient Name: Date:

Date(s) of Service:

Account Number(s): H

Balance Due: $

Dear Patient,

You may qualify for financial assistance in reducing the balance due for your hospital services. As a not-for-profit charitable institution, Lewis County Health System renders medical care to all those in need, regardless of their ability to pay. This is a state funded program based on your financial need. Assistance may be granted for all or a portion of your hospital bill.

If you feel you are in need of assistance to defray the cost of the hospital services you received, please complete the form and attach proof of your family income. You are required to provide proof of **all** sources of income for **all** family members for one year's worth of income. The following documentations are accepted as proof of income:

- Federal income tax return (Form 1040) from the most recent year.
- W-2 forms
- Most recent consecutive pay stubs (3 months worth) along with the **last** pay stub from the previous year showing year to date.
- Copy of Social Security/ Disability income statement. If direct deposit, please provide a copy of your bank statement.
- Copy of your pension/401K/other form of retirement income

A worksheet will be provided for the **self employed** to complete. Please fill out all parts of the application that apply to you; if there is something that doesn't apply to you, fill in with "N/A". Please sign the application and return it to Lewis County Health System, Billing Office.

All information provided to us to determine your eligibility for financial assistance is strictly confidential. If you have any questions regarding the application or if you need help in filling it out, please call (315)376-5210.
If you decide not to complete the application and would prefer a payment plan, please let the billing office know within 14 days of this letter. Thank You.

Sincerely,

Patient Account Clerk

7785 NORTH STATE STREET
LOWVILLE, NEW YORK 13367-1297

PHONE: 315-376-5210
FAX # 315-376-3230

LEWIS COUNTY HEALTH SYSTEM
APPLICATION FOR FINANCIAL ASSISTANCE

DATE: _____

PATIENT NAME: _____ DOB: _____ Marital Status: M S W D

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

COUNTY: _____ PHONE #: _____ SPOUSES NAME: _____

GUARANTOR (if patient is under 18): _____ PHONE # (if different): _____

GUARANTOR ADDRESS (if different): _____ Retired: Y N Spouse retired: Y N

EMPLOYER (Self): _____ EMPLOYER (Spouse): _____

EMPLOYER RETIRED FROM (Self): _____ EMPLOYER RETIRED FROM (Spouse): _____

INSURANCE COMPANY: _____ INSURANCE ID# _____

Family Information: Please list all of the dependents that you support on your taxes. (If more, please put on the back of this page).

Name	Date of Birth	Relationship to Patient

	Annual Patient Income	Annual Spouse Income
Gross Income		
Social Security Income		
Pension/401K/retirement income		
Disability		
Workers Compensation		
Alimony/Child Support		
Unemployment Compensation		
Other income: Interest/rentals/etc		
Total		

Have you included?

A copy of your last 12 weeks income for your household? _____

If your income changed from last year, why did it? _____

I affirm the above information is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility. Also, I agree to inform Lewis County Health System promptly of any change in my needs, income, living arrangements or address.

Please fill out this application to its entirety to be considered for financial assistance.

_____ _____ _____

DATE APPLICANT'S SIGNATURE RELATIONSHIP

Please return to LCHS Billing, 7785 N State St, Lowville, NY 13367, or FAX: (315)376-3230

Self Employed Only

Applicant's Name		**Business Name**	
Applicant's Address		**Business Address**	
Applicant's Phone #		**Business Phone #**	
Note: Depreciation, capital equipment and	personal expenses and payments on the principals	entertainment, personal of loans are **NOT** allowable	transportation, purchase of deductions.
I. Business Income	**Annual**		
	(Mo) / (Yr)	(Mo) / (Yr)	(Mo) / (Yr)
1. Gross Sales			
2. Inventory Purchases			
3. Gross Income (line 1 minus line 2)			
II. Business Expenses	**Deductions**		
4. Telephone			
5. Supplies			
6. Heat/Utilities			
7. Advertising			
8. Interest			
9. Insurance			
10. Bank Charges			
11. Repairs			
12. Business Taxes			
13. Business Vehicle			
14. Business Rent			
A. Property			
B. Equipment			
15. Other expenses			
III. Income Summary	**Summary**		
16. Total Expenses (lines 4 - 15)			
17. Net Income (line 3 minus line 16)			

I certify that I have no other way to document my self-employment income and that all the above information is true and correct. I understand that this information is to be used to determine eligibility for Financial Assistance for Lewis County General Hospital covered services.

Applicant's Signature: **Date:**