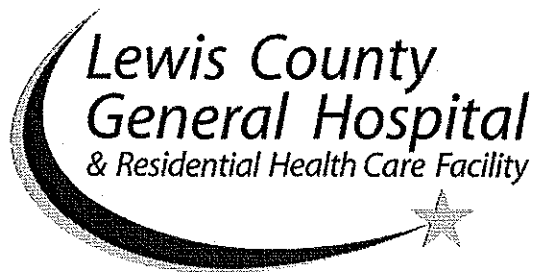

An affiliate of St. Joseph's Health

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 General Hospital renders medical care to all those in need, regardless of their ability to pay.

Eligibility for assistance is based on your financial need. Assistance may be granted for all, or a portion of your hospital bill.

Enclosed is an "Application for Financial Assistance". 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 for the LAST 3 MONTHS.** A worksheet will be provided for the self employed to complete. Make sure to sign the application, and return it to my attention, in care of Lewis County General Hospital.

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 me at (315)376-5210./

If you decide not to complete the application and want to make arrangements for payment, please let me know within 14 days of this letter. Thank You.

Sincerely,

Nancy Boucher, Patient Account Clerk

7785 NORTH STATE STREET
LOWVILLE, NEW YORK 13367-1297

315-376-5210
FAX # 315-376-3230

LEWIS COUNTY GENERAL HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE

Lewis County General Hospital is a not-for-profit facility that renders medical care to all persons in need of such care regardless of their ability to pay.

DATE: ________________

NAME: ____ DOB: ________________

ADDRESS: ____ COUNTY: ________________

CITY: ________________ STATE: _____ ZIP: _________ PHONE #________________

GUARANTOR: ____________________________________ PHONE #________________

ADDRESS: ____

INSURANCE COMPANY: ____

EMPLOYER (Self): ____

EMPLOYER (Spouse):____

TOTAL NO. OF PERSONS IN HOUSEHOLD: _________ AGES: ________________________

	Annual Patient Income	Annual Spouse Income
Wages		
Social Security payment		
Unemployment compensation		
Disability		
Workers compensation		
Alimony/child support		
Dividends/interest/rentals		
All other income		
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 General Hospital promptly of any change in my needs, income, living arrangements or address.

________ ______________________________ ____________________________

DATE APPLICANT'S SIGNATURE RELATIONSHIP

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

LCGH Self Employed Financial Statement

Applicant's Name	Business Name
Applicant's Address	**Business Address**
Applicant's Phone #	**Business Phone #**

Note: Depreciation, personal expenses and entertainment, transportation, purchase of capital equipment and payments on the principals of loans are **NOT** allowable 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:**