ROME
MEMORIAL HOSPITAL
Total commitment. Total care.

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 or questions you might have please contact our Financial Assistance Coordinator in our Business Office located at 155 West Dominick Street in Rome at (315) 338-7071. We will treat your questions with confidentiality and courtesy. You can also visit our website at www.romehospital.org/FinancialAssistance.

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

FREE OR LOW-COST HEALTH INSURANCE:

Rome Memorial Hospital's Certified Application Counselors can help you enroll in an insurance program that fits your budget and needs including Medicaid, Healthy NY, Child Health Plus or a NY State of Health qualified health plan including the ***Essential Plan which is new for 2016 (See page 2 for income guidelines).*** **The essential plan may be free of charge or have a very low monthly premium, depending on your income. To schedule a confidential appointment, please call (315) 356-7723 or 356-7724.**

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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 or a Certified Application Counselor.
- Application for financial assistance from the hospital must be made within 240 days from the date of your first bill.
- If you are over the Medicaid income guidelines (as decribed below) or are denied for Medicaid assistance due to excess income, complete the application for financial assistance.
- **Provide proof of income for All Household Members. Proof may be in the form of the most current: 1040 Tax Form (including ALL Schedules), paystubs (preferably 1-2 months worth), Social Security Statement, etc.**
- 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 or for Financial Assistance Through Rome Memorial Hospital (RMH)?

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. The second chart shows you how much income you can receive and still qualify for aid.

YEARLY INCOME EFFECTIVE JANUARY 25, 2016				
TO QUALIFY FOR MEDICAID			**TO QUALIFY FOR AID FROM RMH**	
Number Of Family Members	**Maximum Yearly Income**		**Number Of Family Members**	**Maximum Yearly Income**
1	$16,394		1	$35,640
2	$22,107		2	$48,060
3	$27,820		3	$60,480
4	$33,534		4	$72,900
5	$39,247		5	$85,320

2016 ESSENTIAL PLAN YEARLY INCOME GUIDELINES			
TO QUALIFY FOR FREE COVERAGE		**TO QUALIFY FOR A SMALL MONTHLY PREMIUM**	
Number Of Family Members	**Maximum Yearly Income**	**Number Of Family Members**	**Maximum Yearly Income**
1	$17,820	1	$23,760
2	$24,030	2	$32,040
3	$30,240	3	$40,320
4	$36,450	4	$48,600
5	$42,660	5	$56,880

155 West Dominick Street, Rome, New York 13440 • (315) 338-7071

ROME MEMORIAL HOSPITAL

BUSINESS OFFICE
155 West Dominick 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

Send Proof Of Income For ALL Household Members Along With Application

Your Gross Income		☐Weekly	☐Monthly	☐Yearly	Family Size
Spouse's Gross Income		☐Weekly	☐Monthly	☐Yearly	
Other Income: ie; rental, child support, alimony, etc…		☐Weekly	☐Monthly	☐Yearly	
Total Family Income		☐Weekly	☐Monthly	☐Yearly	

List Household Members	Age	Relationship	List Household Members	Age	Relationship

Date(s) of Service: (if known)			

Circumstances requiring this application (This section must be completed): ☐Uninsured ☐Financial Hardship ☐Other (please explain): _____

_____

_____

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) 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 ☐Insured

☐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): ☐Incomplete Application

☐Over Income Limits ☐No Eligible Accounts ☐Other: _____

Date of Final Determination: _____ Approved/Denied By: _____