Rome Health
An affiliate of St. Joseph's Health

# FINANCIAL ASSISTANCE PACKET

Rome Health 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 Health 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 245 Hill Road in Rome at (315) 338-7077.**
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 HEALTH
BUSINESS OFFICE
245 Hill Road
Rome, New York 13441

## FREE OR LOW-COST HEALTH INSURANCE:

Rome Health'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 (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, we strongly urge you to 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 Health until you receive a written decision.
- Each approved application is valid for one year.

**How do I know if my income qualifies me for**
**Medicaid or Financial Assistance Through Rome Health?**

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

| YEARLY INCOME EFFECTIVE JANUARY 17, 2024 | | | | |
|---|---|---|---|---|
| TO QUALIFY FOR MEDICAID | | | TO QUALIFY FOR AID FROM RMH | |
| Number Of Household Members | Maximum Yearly Income | | Number Of Household Members | Maximum Yearly Income |
| 1 | $26,973 | | 1 | $45,180 |
| 2 | $36,482 | | 2 | $61,320 |
| 3 | $45,991 | | 3 | $77,460 |
| 4 | $55,500 | | 4 | $93,600 |
| 5 | $65,009 | | 5 | $109,740 |

| 2024 ESSENTIAL PLAN YEARLY INCOME GUIDELINES | |
|---|---|
| TO QUALIFY FOR FREE COVERAGE | |
| Number Of Household Members | Maximum Yearly Income |
| 1 | $29,160 |
| 2 | $39,440 |
| 3 | $49,720 |
| 4 | $60,000 |
| 5 | $70,280 |

**ROME HEALTH**
BUSINESS OFFICE
245 Hill Road, Rome, New York 13441

## 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 # (Optional) | 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:** _____

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## ELIGIBILITY DETERMINATION (For Office Use Only)

Date Application Received: _____ Income Verified: ☐Yes ☐No ED Visit: ☐Yes ☐No Insured : ☐Yes ☐No

☐The Applicant is Approved: _____

Amount provided as uncompensated services is: ☐90% ☐80% ☐55% ☐30% ☐5% of: ☐PP Balance or ☐AGB

☐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: _____