Financial Assistance Summary

Cuba Memorial Hospital recognizes that there are times when patients in need of care will have difficulty paying for the services provided Cuba Memorial Hospital's financial assistance program provides discounts to qualifying individuals based on income and family size. In addition, we can help you apply for free or low-cost insurance if you qualify.
Please contact our Patient Financial Liaison at 716-375-6080 for free confidential assistance.

Who qualifies for a discount?

- Financial assistance is available for patients with limited incomes and no health insurance.
- Anyone who needs emergency services can receive care and get a discount if they meet the income limits.
- Everyone who lives in Allegany County or the surrounding area can get a discount on non-emergency medically necessary services at Cuba Memorial Hospital if they meet the income limits. You cannot be denied medically necessary care because of your financial status.
- Financial assistance is contingent upon a patient's cooperation in following Cuba Memorial Hospital's application requirements as listed below.

What are the income limits?

The amount of the discount varies based on your income and the size of your family. The income limits are listed below:

Family Size	Annual Family Income	Monthly Family Income	Weekly Family Income
1	$51,521.00	$4,293.42	$1,073.35
2	$69,681.00	$5,806.75	$1,451.69
3	$87,841.00	$7,320.08	$1,830.02
4	$106,001.00	$8,833.42	$2,208.35
5	$124,161.00	$10,346.75	$2,586.69
6	$142,321.00	$11,860.08	$2,965.02

*Based on the 2021 Federal Poverty Guidelines

What if do not meet the income limits:

If you cannot pay your bill all at once, Cuba Memorial Hospital offers a payment plan to those patients that do not meet the above income limits. The amount you pay depends on your income

Can someone explain the discount? Can someone help me apply?

- Yes, free confidential help is available. Call our Patient Financial Liaison at 716-375-6080.
- A hospital representative can advise you how to apply for free or low-cost insurance such as Medicaid.

If the Patient Financial Liaison finds that you do not qualify for low-cost insurance, they will help you apply for a discount. You will receive help completing forms and they will tell you what documents you need to provide.

What do I need to apply for a discount?

- Cuba Memorial Hospital will require a completed Financial Assistance application and proof of income such as a tax return or pay stubs. We may also request a Medicaid denial letter.
- If you cannot provide any of these, you may still be able to apply for financial assistance.
- Financial assistance applications may be obtained from our financial liaison cashier and/or Registration department. You may also request an application and copy of our policy by submitting a written request to:

  Cuba Memorial Hospital
  Attn: Patient Financial Liaison
  140 West Main Street
  Cuba, NY 14727

What services are covered?

All medically necessary services provided by Cuba Memorial Hospital are covered by the discount. This includes outpatient services, emergency care, and inpatient admissions.

How much do I have to pay?

Financial Assistance eligible individuals will not be charged more than the "amounts generally billed" to insured individuals for emergency or other medically necessary care. This is referred to the AGB or the "self-pay" rate.

Depending on your income, you could qualify for up to 100% off the self-pay rate. Our Patient Financial Liaison will provide you with details about your specific discount(s) once your application is processed.

How do I get the discount?

- Fill out the application form. Once we have proof of your income, we can process your application for a discount according to your income level.
- You can apply for a discount before you have an appointment when you come to the hospital to get care or when the bill comes in the mail.
- Send a completed form to Cuba Memorial Hospital or leave it with the cashier located in the main registration area. You have up to 90 days after receiving services to submit the application.

How do I know if I was approved for the discount?

You will receive a letter from Cuba Memorial Hospital (usually within 30 days after completion and submission of documentation) telling you if you have been approved and the level of discount received

After applying the self-pay discount and/or after being approved and assigned to the appropriate financial class, you will be billed for any balance due. If the account remains unpaid after appropriate billing attempts, the account may be sent to a collection agency.

What if I receive a bill while I am waiting to hear if I can get a discount?

You cannot be required to pay a hospital bill while your application for a discount is being considered. If your application is turned down, the hospital must tell you in writing the reason why it was turned down and provide you with a way to appeal this decision to a higher level within the hospital.

What if I have a problem with the hospital that I cannot resolve?

You may call the NY State Department of Health complaint hotline at 1-800-804-5447.

No one will be denied medically necessary services based on the inability to pay.

Cuba Memorial HOSPITAL
140 West Main Street • Cuba, NY 14760
(716) 375-6080 • Fax (716) 375-6936

APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM

Date of Request: _____

Request for Determination of Eligibility for Financial Assistance Program

I hereby request that Cuba Memorial Hospital make a written determination of my eligibility for the Financial Assistance Program. I understand that the information requested below concerning my annual income and family size is subject to verification by the Cuba Memorial Hospital. I also understand that if the information submitted is determined to be false, such determination will result in a denial of providing services as uncompensated services, and that I will be liable for all charges for services provided. No one will be denied medically necessary services for the inability to pay.

Please send the following information along with your completed application:

1. **Proof of Income** – copy of pages 1 & 2 of your _____ Federal Income Tax
   (If you did not file an income tax return, other acceptable proof of income includes: last 3 months wage stubs, or statement from employer; copy of Social Security benefits; copy of unemployment benefits, etc.)
2. **Denial from Medicaid**

Complete the following:

Patient (full) Name: _____ SS #: _____

Address (street): _____

Address (city/state/zip): _____ Phone #: _____

Employer: _____

Charity Care Requested by: _____ Number in household: _____

Name	Relationship

If you are seeking charity care for services already rendered by Cuba Memorial Hospital, list the date(s) of service:

_____

If you are seeking an eligibility determination for services not yet rendered, check the type of service sought:
☐Emergency Room ☐In-patient ☐Other

List the expected date(s) of Service: _____

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: _____

DO NOT COMPLETE - FOR HOSPITAL PERSONNEL USE ONLY

This document was received on _____ by _____

The following documents were proved to verify income and family composition.

RETURN ORIGINALS TO PATIENT. ☐Paycheck stubs ☐Income Tax Form ☐Other _____