Patient Name:

Date(s) of Service:

Account Number(s): H

Balance Due: $

Dear Patient:

You may qualify for financial assistance in reducing the balance due for the hospital services noted above. 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 household INCOME for the LAST MONTH. 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 the number listed below.

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          (315) 376-5210
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: ________________

PATIENT NAME: ______________________________ AGE: ________________

ADDRESS: _______________________________ COUNTY: ________________

CITY: _______________ STATE: ___ ZIP: _______ PHONE #: ________________

GUARANTOR: ______________________________ PHONE #: ________________

ADDRESS: __________________________________________

INSURANCE COMPANY: ______________________________

EMPLOYER (Self): ______________________________

EMPLOYER (Spouse): ______________________________

TOTAL NO. OF PERSONS IN HOUSEHOLD: _______ AGES: ______________________________

<table>
<thead>
<tr>
<th>Wages</th>
<th>Annual Patient Income</th>
<th>Annual Spouse Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment compensation</td>
<td></td>
<td></td>
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<tr>
<td>Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workers compensation</td>
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<td></td>
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<tr>
<td>Alimony/child support</td>
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<td></td>
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<tr>
<td>Dividends/interest/rentals</td>
<td></td>
<td></td>
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<tr>
<td>All other income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you included

A copy of your last 4 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 Nancy Boucher at LCGH, 7785 N State St, Lowville, NY 13367