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Patient Guide
Information and tools for our patients and their families.

Patient Financial Assistance Program

Lourdes was established by the Daughters of Charity in 1925 to serve the people of this area, especially those in need. Today, we continue our strong commitment to provide services to patients regardless of their ability to pay.

Patients and/or Guarantors are responsible for payment of bills for services provided by Lourdes. Lourdes has established the Patient Financial Assistance Program to help patients who meet the income and resources guidelines established by Lourdes, and who are not eligible for any other available program, such as Medicaid, Child Health Plus, Family Health Plus, etc. It can also be used to assist with any copays or deductibles of other programs. If we believe that you are eligible for any other program, you must apply to that program and receive in writing, an approval or denial before we can determine if you are eligible for the Lourdes Patient Financial Assistance Program. This requirement enables us to serve as many people as possible with our limited funds. This program is available to the extent Lourdes' resources allow.

A financial scale based on federal poverty income guidelines determines your eligibility for the Patient Financial Assistance Program. How much your Lourdes bill will be discounted depends on how your gross income and resources compare with this financial scale.

If you are found eligible, your discount will apply to all charges generated by Lourdes. Some services received at Lourdes are provided by private physician groups, such as the services of a Radiologist or Anesthesiologist, and are not covered because the bill you receive is not a Lourdes bill. A Lourdes Patient Financial Counselor will be happy to answer any questions and to help you clarify your charges.

To Apply for Lourdes Patient Financial Assistance Program:

1. Download and Complete the application (PDF).
2. Please include the names and dates of birth of each adult who are applying for assistance. If children under 21 are

http://www.lourdes.com/patient-guide/uninsured/pfap

7/8/2010
involved, we need the names and dates of birth of the parents as well as all children under 21 in the family.

3. Provide proof of total household income. Copies of pay stubs for the most recent four week period, or a letter from your employer stating average monthly wages. Include copies of unemployment stub, Social Security benefits, monthly pension or any other sources of monthly income.

4. We also need proof of any resources you may have. Resources include checking/savings accounts, stocks, bonds and real estate property other than your primary residency. We do not include your home, tax deferred retirement or college savings funds, or vehicles used by your immediate family.

5. Mail the completed application and copies of required proofs to the address at the bottom of the application. We will contact you once your application has been reviewed. If your application is denied, you may appeal this decision to the Health Care Access Committee.

If you wish to speak with a financial counselor contact the cashiers office at Lourdes Hospital at 607-798-5506 or 607-798-5279.
PATIENT FINANCIAL ASSISTANCE PROGRAM APPLICATION

Applicant’s Name: __________________________________________

Address: ___________________________________________________

City: ___________________________ State: ___________ Zip: ___________

Telephone: (__________)________________________ Date of Birth: ___________

Family Members (List all members living in household and their date(s) of birth):

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*** APPLICANTS MUST SUBMIT ALL REQUIRED DOCUMENTS IN THE SAME MAILING. INCOMPLETE APPLICATIONS (THOSE MISSING ANY OF THE DOCUMENTS LISTED BELOW) WILL BE RETURNED.

THE FOLLOWING DOCUMENTATION IS REQUIRED TO DETERMINE ELIGIBILITY:

1. Proof of income:
   (submit all documentation that applies to your household)
   ☐ Pay stubs for most recent 4 weeks for each working member of household.
   ☐ Unemployment or Workers Compensation statement.
   ☐ Social Security benefit letter or bank statement if you use Direct Deposit.
   ☐ Pension statement.

2. Other resources:
   A. Do you have checking, savings, stocks, or bonds?
      ☐ YES (If YES provide a current official 30 day bank statement mailed from the bank)*
      ☐ NO
   B. Do you own property that you do not live in?
      ☐ YES (If YES attach copy of current assessed value)*
      ☐ NO
   C. Do you have any other sources of income?
      ☐ YES (If YES attach letter with description of income)*
      ☐ NO

* Information about other resources is required if you answered YES to any items listed above.

I affirm by my signature below that the information contained on this application is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility. I agree to inform Lourdes promptly of any changes in my needs, income, living arrangements or address.

Applicant’s Signature  ________________

Relationship (if other than patient)  ________________

Date  ________________

OFFICE USE ONLY

Discount % Approved __________________________
Date Approved __________________________
Approval Signature __________________________

MAIL APPLICATION TO:
Lourdes Hospital
Patient Financial Assistance Program
169 Riverside Drive
Binghamton, NY 13905
Phone: (607)798-5506 or (607)798-5279
www.LOURDES.com