Dear Patient:

Attached is a Moses-Ludington Hospital Patient Financial Assistance Application. The financial disclosure form must be complete and accurate. You have 90 days after you receive services in which to complete and return this application for financial assistance.

Please include:
- Copies of three (3) consecutive pay stubs, a letter from your employer indicating all income for the previous three (3) months or a copy of your most recent tax return.
- One (1) form of identification.
- One (1) proof of residency.

A Medicaid determination letter must also accompany the application if your monthly net income is below $1,417.00.

All applicants will be notified of their eligibility. Some participants will be responsible for a portion of their bills. Arrangements for payment should be made with the Patient Accounting Department. If a patient does not make arrangements with the Patient Accounting Department for payment of their responsibility, assistance will cease.

Eligibility for this program is based upon income in accordance with established procedures and without regard to race, creed, color, sex, national origin and/or any other prejudgment. Acceptance is only for medically necessary services performed by Moses Ludington Hospital. It does not cover physician services, radiologist services, ambulance services or consulting physician fees or services provided by other Inter-Lakes companies.

If you have any questions please feel free to contact our Financial Counselor at (518)585-3900 or our Patient Accounting Representative at (518)585-3788.
INTER-LAKES HEALTH, INC.
MOSES-LUDINGTON HOSPITAL
1019 Wicker ST.
Ticonderoga, NY 12883

PATIENT FINANCIAL ASSISTANCE APPLICATION

Name: __________________________________________

Address: _______________________________________

________________________________________________________________________

Phone: _________________________________________

Family size / number in household:_____________________

Note: To be considered for financial assistance each patient must complete an application. “Joint” applications will not be processed.

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

I affirm that the above information is true, complete and correct to the best of my knowledge.

Signed ______________________________________ Date: __________________

If you have any questions or need help completing this application, please call Patient Accounting Department at (518) 585-3788.

If you have received a bill or bills from the hospital, check here: __________

You do not have to make any payment to the hospital until the hospital sends you a letter with its decision on your application.

Please send completed form and attachments to:

Patient Accounting Department
Moses Ludington Hospital
1019 Wicker Street
Ticonderoga, NY 12883