NATHAN LITTAUER
Hospital & Nursing Home

For Hospital Use Only:
Patient Name: _____
Account #: _____
Date Mailed/Given to Pt: _____
By Whom: _____
Dept: _____

Financial Assistance Application

Nathan Littauer Hospital is committed to providing medical care to those patients who may not have sufficient financial resources to meet their medical care needs. To apply for financial assistance for your Nathan Littauer account(s), The Financial Assistance Application must be completed, signed and returned to the hospital. Please return all supporting documents with the application. Upon filing a completed application, you may disregard any Nathan Littauer Hospital bills until you receive notification of determination of your application. **APPLICATION AND DOCUMENTATION MUST BE RETURNED TO NATHAN LITTAUER HOSPITAL, 99 E. STATE ST, GLOVERSVILLE, NY 12078 ATTN: PATIENT FINANCIAL SERVICES OR SUBMITTED TO YOUR OUTPATIENT CLINIC.**

Upon review of the application, further information may be requested of you. Any potential source of payment, including state and federal assistance programs, all insurance sources, and legal settlements, must be exhausted before forgiveness of account balances will be considered. Patients at or below 200% of the Federal Poverty Guidelines will only be evaluated using family size and income. Your application for assistance will be given equal consideration in a non-discriminatory manner. **Please understand that this application is for consideration of Nathan Littauer Hospital Association (Hospital and outpatient primary/specialty care clinics) charges only and DOES NOT cover billing from your private physician, radiologist, emergency room physician, consulting physician, hospital retail pharmacy or any other services not directly provided by the hospital.**

For questions or to inquire about the status of your application, please call **518-773-5551.**

Patient Name (Last, First, MI)

Date of Birth

Address

Mailing Address (if different from residence)

County of residence _____ Home phone _____

Employer _____ Phone _____ How long? _____

Previous Employer _____ Phone _____ How long? _____

Other income earner employer _____ Phone _____

Insurance

If you have medical insurance, please provide that information below. Also, if your hospitalization is the result of an injury or accident, please provide us with the necessary Auto/Homeowner's, Workers Compensation or Third Party insurance below:

Insurance Co. _____ Policy # _____

Address _____ Phone # _____

City/State/Zip _____ Insured _____ SSN#(Optional) _____

Attorney Name/Address/Phone # _____

Nature of Injury or Accident _____ Police Report # _____

Household Members and Income Information

Please list all household members and include all sources of income for each household member, including non-employment sources such as Worker's Compensation, Unemployment Compensation, pensions, rental income, interest from investments, dividends, trust funds, child support, alimony, income from Social Security, Veterans Administration or other benefit program.
Please send all copies of pay stubs or any other forms of gross income.

Family Members/Other	**Monthly Gross Income**	
Self	$	Source
Other Household Earners	$	Source
Other Household Earners	$	Source
Dependent Children	$	Source
Name	Date of Birth	

Name	Date of Birth
Name	Date of Birth
Other Children	
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Total Family Members/Earners	

Total Monthly Gross Income

$_____

Financial Assistance Application

Application to or participation in public or private health insurance is not a determining factor for financial assistance for patients at or below 200% of the Federal Poverty Level

Have you filed for any state or federal assistance during the past year? _____ Date of application _____

Medicaid Y N Social Security Disability Y N Victims Compensation Y N

Please list any recent accounts that you or your immediate family members may have at Nathan Littauer Hospital or one of our Primary Care Sites.

Patient Name	Account #	Date of Service

I certify that the above information is true and accurate to the best of my Knowledge.

Signature of applicant: _____

Date: _____

For Hospital Use Only: ☐ Referred to DSS ☐ SSI ☐ Victim's Comp ☐ Other: _____

Account Number	Reviewed	Approved	Denied	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

_____ _____

Patient/Parent/Guardian Signature Date

Rev 1/2024

2024 Financial Assistance Income Guidelines

Family Size	Federal Poverty Level				
	100% FPL	0- 200% FPL	201%- 300% FPL	301%-400%	
1	$ 15,060.00	$ 30,120.00	$ 45,180.00	$ 60,240.00	Over
2	$ 20,440.00	$ 40,880.00	$ 61,320.00	$ 81,760.00	Over
3	$ 25,820.00	$ 51,640.00	$ 77,460.00	$ 103,280.00	Over
4	$ 31,200.00	$ 62,400.00	$ 93,600.00	$ 124,800.00	Over
5	$ 36,580.00	$ 73,160.00	$ 109,740.00	$ 146,320.00	Over
6	$ 41,960.00	$ 83,920.00	$ 125,880.00	$ 167,840.00	Over
7	$ 47,340.00	$ 94,680.00	$ 142,020.00	$ 189,360.00	Over
8	$ 52,720.00	$ 105,440.00	$ 158,160.00	$ 210,880.00	Over
	100%	100%	90%	80%	0
	Discount Amount %				

* For family units of more than 8 members, add $5,380 for each additional member.

https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Effective 10/20/24

PA019B