Financial Assistance Summary

Garnet Health understands that there are times when patients in need of care will have difficulty paying for the services provided. Our Financial Aid program provides discounts to qualifying individuals based on your income.

The Application for Financial Assistance and Financial Assistance Policy (Policies) are available at patient registration areas of each Hospital Facility and may also be downloaded from the internet free of charge at www.garnethealth.org, under ***Pay My Bill*** options, Patients may also request a copy to be mailed free-of-charge to their home upon request by telephone or writing to the following areas:

Garnet Health Medical Center/
Garnet Health Doctors / Urgent Care
Financial Advocate Office
707 East Main Street
Middletown, NY 10940
845-333-1888

Garnet Health Medical Center - Catskills/
Garnet Health Doctors/ Urgent Care
Credit & Collections
P.O. Box 800
Harris, NY 12742
845-333-8989

What services are covered?

Patients will not be denied access to services due to inability to pay; there is a discounted/sliding fee schedule available based on family size and income.

Only medically necessary services provided by a Garnet Health provider are covered by the discount. This includes outpatient services, emergency care, inpatient admissions, and physician services.

Services not provided by a Garnet Provider in the hospital are ***not*** covered by the hospital discounts. You should talk to your outside doctors to see if they offer a discount or payment plan. For your convenience, you can find our current doctors on our website at www.garnethealth.org at Find A Doctor

Who qualifies for a discount?

Any patient who is a resident of the State of New York is eligible for financial assistance through Garnet's program for emergency services for residents of the State of New York. For all other services, it is the policy of Garnet Health to provide the level of financial assistance to emergent, urgent, and medically necessary treatment to patients who reside in Garnet Health's primary service areas, as well as patients that work, reside or visit the primary service areas. Garnet Health reserves the right to refuse to provide financial assistance for elective services.

Patients cannot be denied admission or denied medically necessary treatment or services because of unpaid medical bills.

Immigration status shall not be considered when determining eligibility.

What are the income limits?

Eligibility for financial assistance is based on family income, size, and, in some cases, other information you provide. If, after reviewing your application, Garnet Health determines that your income is at 400% of Federal Poverty Limits (FPL) or below, you will be eligible for a discount on our bill for eligible services. In 2025, the maximum income levels for eligibility at 400% of FPL are shown below.

Garnet Health

Sliding Scale for Uninsured and Underinsured
2025

Family Unit	1	2	3	4	5	6	7	8	Discount of Patient Responsibility	Discount of Patient Responsibility
FPL	$15,650	$21,150	$26,650	$32,150	$37,650	$43,150	$48,650	$54,150	*100%*	*100%*
% Above FPL										
200 and below	$31,300	$42,300	$53,300	$64,300	$75,300	$86,300	$97,300	$108,300	*100%*	*100%*
201 - 300	$46,950	$63,450	$79,950	$96,450	$112,950	$129,450	$145,950	$162,450	Uninsured (Patient responsibility is 10% at Medicaid Rate)	Underinsured (Patient responsibility is 10% of balance)
301 - 400	$62,600	$84,600	$106,600	$128,600	$150,600	$172,600	$194,600	$216,600	Uninsured (Patient responsibility is 20% at Medicaid Rate)	Underinsured (Patient responsibility is 20% of balance)
More than 400% above FPL not eligible									0%	0%

Budget up to 5% of income per month

For families/households with more than 8 persons, add $5,500 for each additional person.

Gross income means your income before taxes are deducted. Gross income can consist of work earnings (wages, salaries, tips, earnings from self- employment), unearned income (social security, disability, and unemployment benefits), contributions (funds from family or friends), and other sources of income (temporary assistance and supplemental security income).

Family members mean all family members in your household. Your household includes yourself, your spouse or domesticpartner, and any children or other dependents. For example, this would include everyone listed on the same tax return.

What if I do not meet the income limits?

If you cannot pay your bill, Garnet Health offers a payment or budget plan for monthly payments, which will not exceed 5% of household income.

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

Yes, free, confidential help is available. If you do not speak English, someone will help you in your own language. The Financial Assistance Policy and application are available in Spanish and Yiddish on our website as well as in the Patient Access areas of Garnet Health.

The Financial Advocate can assist you in applying for insurance through NYS Marketplace. If you do not qualify for Medicaid or other low-cost insurance, they will help you apply for a discount.

How to Apply for Financial Assistance: An evaluation of the patient's financial situation will be completed with the use of a Financial Assistance Application (with supporting documentation from the patient/responsible party).

It is prohibited for any hospital, health care provider, or employee/agent of a hospital or health care provider to complete any portion of an application for medical financial products for the patient, or otherwise arrange for or establish an application that is not completely filled out by the patient. Providers may answer patient's questions and provide assistance if requested, so long as the application is completed wholly by the patient.

- All applications must be signed and dated by the person making the request.
- Applications will not be deemed completed until all income documentation required is provided.
- All applications will indicate the date, name and title of the Garnet Health employee reviewing the said application.
- As part of financial assistance counseling, the patient will be screened for Medicaid eligibility, if still within the timeframe (90 days) from the date of service.

Financial Assistance Eligibility Determinations: Determination of eligibility will be made, in writing, to each applicant within 30 days of receipt of complete application and documentation. Immigration status is not considered when determining eligibility. Determinations will be based on the application and information submitted. A Patient's Assets (such as residence, car, etc.) may not be considered. Eligibility for financial assistance is determined solely based on household income.

A copy of all determinations will be kept on file.

Appealing a Financial Assistance Eligibility Determination: Once a denial determination is made, the patient will have 30 days from receipt of written notification to submit an appeal with supporting documentation. The denial determination shall include the following information on how to appeal:

- If it is determined that the patient does not qualify for the Financial Assistance program, the patient will be informed in writing within thirty (30) business days of the denial. All reasons for denial will be provided in the correspondence, including information on how to appeal the denial.
- The appeal and supporting documentation will be reviewed by the Director of Revenue Cycle Shared Services within twenty (20) days of the decision.
- The Revenue Cycle leadership shall have fifteen (15) business days to review the appeal and respond to the patient in writing.
- If the patient remains dissatisfied with the Revenue Cycle Leaders decision, the patient may appeal the leader's decision in writing, including reasons therefor, and any supporting documentation to the Hospitals Chief Financial Officer (CFO).
- The Chief Financial Officer shall decide to write within fifteen (15) days of receipt of the appeal; and their decision shall be final.
- No collection activity shall be pursued during the pendency of any appeal.

Length of Eligibility and Patient Rights

Eligibility will be granted for a period of six (6) months. You will need to recertify at the end of the eligibility period.

If you are denied financial assistance, you have the right to appeal.

- Please contact Garnet Health Financial Advocate office at 845-333-1888 or 845-333-8989 for assistance.
- If you need additional assistance with this application or help appealing a decision, you can reach out to Community Health Advocates: 888-614-5400.

Any information provided in this application will only be used by the hospital to determine your eligibility for financial assistance and will remain confidential to the extent permitted by law.

Amounts generally billed by a Hospital Facility for Emergency Services or Medically Necessary Services to individuals who have Medicare.