



# **Financial Assistance Program Policy and Procedure**

## **Cayuga Health System**

As a service to our patients, hospital financial counselors are available to discuss whether or not a patient may qualify for publicly sponsored New York State & Federal health insurance programs. These programs include, but are not limited to Medicaid and Medicare. In addition to these insurance programs, Cayuga Health System offers full or partial financial assistance to those individuals who are eligible based on income guidelines set forth in this policy.

## **Section 1 - Financial Assistance Program Policies**

### **a - Costs and Services Eligible for Financial Assistance**

Cayuga Health System provides Emergency Care and Medically Necessary services, without regard to a patient's source of payment. Financial assistance is available for eligible patients (defined below) to help ease the burden of the cost of Emergency Care and Medically Necessary services they are provided, but the provision of that care will never be contingent on a patient's eligibility for the Financial Assistance Program (FAP).

Patients will not be denied admission or denied medically necessary treatment or services because of an unpaid medical bill.

Cayuga Health System's Financial Assistance Policy applies to the following organizations:

1. Cayuga Medical Center
2. Schuyler Hospital
3. Cayuga Addiction Recovery Services
4. Cayuga Health Transport
5. Visiting Nurse Services
6. Cayuga Medical Associates

## **Definitions**

### **Emergency Care:**

As required by Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act (42 U.S.C. 1395dd), Emergency Care is care required as a result of a sudden onset of a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity, including but not limited to

severe pain, that a prudent patient who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the patient's health in serious jeopardy, or in the case of behavioral condition placing the health of such person or others in serious jeopardy,
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or body part, or
4. Serious disfigurement of the patient.

### **Medically Necessary Care:**

Health services that are reasonably necessary to prevent illnesses or medical conditions, or provide early screening, diagnosis, intervention, and/or treatment for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of an Enrollee, or endanger life, which are provided at appropriate facilities and levels of care, consistent with accepted local health care practices and standards in literature, and which are not experimental or primarily for the convenience of the patient.

### **Services Not Eligible for Financial Assistance:**

Financial assistance is only available for costs associated with Medically Necessary Care and therefore such discounts are not available to cover the costs of medically unnecessary care such as, but not limited to, cosmetic surgery, or other services that are provided primarily for the convenience of the patient, his/her family or provider.

## **b -Financial Assistance Eligibility Requirements**

Financial assistance is available for uninsured and underinsured patients who reside in New York State in Cayuga Health System's Primary or Secondary Service Area (see Appendix I) and whose household income is at or below 400% of the most recent Federal Poverty Guidelines. Eligibility for financial assistance will not be determined by a patient's assets or immigration status. Per section 2807-k of the NYDOH regulations, patients can qualify for financial assistance under the following conditions:

1. Low income patients with no health insurance; or
2. Low income patients who have exhausted their insurance benefits; or
3. Low income patients who have an inability to pay co-pays and deductible amounts, at the hospital's discretion.

## **c - Determination of Patient Payment**

<b>Income Level</b>	<b>Payment</b>
Below 200% FPL	Waive all charges
200% - 300% FPL	<b>Uninsured patients:</b> Sliding scale up to 10% of the amount that would have been paid for the services(s) by Medicaid. <b>Underinsured patients:</b> Up to a maximum of 10% of the amount that would have been paid pursuant to such patient's insurance cost sharing.

301% - 400% FPL	<p><b>Uninsured patients:</b> Sliding scale up to 20% of the amount that would have been paid for the services(s) by Medicaid.</p> <p><b>Underinsured patients:</b> Up to a maximum of 20% of the amount that would have been paid pursuant to such patient's insurance cost sharing.</p>
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### **Residency Eligibility Criteria**

To qualify for financial assistance you must live in Cayuga Health System's service area which includes the following counties: Cayuga, Chemung, Cortland, Schuyler, Tioga, and Tompkins.

## **d-Determination of Poverty Levels – Income & Assets**

**Income** - Income poverty levels must be updated and adopted annually by April 1<sup>st</sup> using the current year's income levels published on the US Department of Health and Human Services website:

<http://aspe.hhs.gov/poverty-guidelines>

**Assets** – Assets will not be taken into account when determining FAP eligibility or level of sliding discount an eligible patient will receive.

## **e-Notification of FAP Availability**

### **Brochures**

Brochures will be updated when there are any significant changes to the FAP policy.

### **Community**

The following local organizations have been identified as organizations that serve the communities most in need of the financial assistance program:

CMC & CMA:

- Ithaca Health Alliance
- Planned Parenthood
- United Way of the Southern Tier
- Mental Health Association of Tompkins Count

Schuyler Hospital:

- Schuyler County Public Health
- Office for the Aging
- Catholic Charities
- United Way of Schuyler County

These organizations are to be reviewed annually in April by the Community Relations Department to ensure they still serve the populations of interest to Cayuga Health System and should be provided with updated brochures about our financial assistance program to distribute as they see fit.

## **Patient**

1. Patient must be uniformly notified by registration upon arrival that financial assistance is available. Patients will be notified with the provision of a financial assistance brochure that meets PLS standards (defined below) or the PLS itself.
2. Plain Language Summary (PLS) - A written statement which notifies the patient that the hospital offers financial assistance and provide additional info in a clear, concise, understandable manner and include the following:
  - a. Eligibility requirement and type of assistance offered
  - b. Brief Summary of how to apply for assistance
  - c. Website and physical location where an individual can obtain copies of FAP and FAP application form
  - d. Contact information of a source that may assist with form
  - e. Statement addressing the availability of translations
  - f. A statement that FAP eligible individuals may not be charged more than amounts generally billed
3. Brochures must be made available in plain sight (at a minimum in the ED & Admission areas) and produced upon request by the patient at no cost. Brochures must be update whenever a substantial change to the FAP is made.
4. Website – website must be updated whenever there are significant changes to any of the following items:
  - a. PLS
  - b. Asset or Income Levels
  - c. Provider List

## **f - Adoption Process for Financial Assistance Policy**

Any substantive changes to the financial assistance policy must be approved and adopted by the Finance Committee of the hospital.

## **Section 2 - Financial Assistance Program Application Process**

### **a - Government Assistance**

In determining whether each patient qualifies for the Financial Assistance Program, other county, and state or federal financial assistance programs may be considered as options for the patient. A financial counselor will assist the patient in determining if they are eligible for any governmental assistance by utilizing the current guidelines provided by our local Department of Social Services. If a patient qualifies for state or federal assistance, but needs additional help paying for medical bills, the patient is allowed to apply for the hospital's financial aid program.

**NOTE:** New York State Health Care Law prohibits CHS from requiring all patients to apply for State/Federal insurance programs (e.g. Medicaid) as a pre-requisite to apply for the FAP. Additionally, CHS is not allowed to delay the processing of FAP applications, when an applicant is waiting for an eligibility determination from a State/Federal insurance program. It is important CHS facilitates the application to State/Federal insurance program for those patients who are likely to qualify, but FAP determinations should be paid independent of eligibility for State/Federal insurance programs.

## **b - Application Process**

Any patient who indicates the financial inability to pay for Emergency Services or Medically Necessary services may apply for financial assistance.

**Notification Period:** The hospital will make a good faith effort to inform the patient financial assistance is available at any time during the collection process.

**Application period:** A patient will be allowed to apply for financial assistance any time during the collection process.

## **c - Availability of the Application**

The patient may request an electronic and/or a paper copy of the application material at no cost to the patient.

## **d - Completion of Application**

The patient is responsible for ensuring that his or her application is complete. The hospital is responsible, in accordance with IRS regulations, to provide assistance with said application. A completed application shall include all the necessary documentation outlined in this Financial Assistance Policy. Information provided on an application is subject to verification. Patients submitting incomplete applications or whose information cannot be verified will be notified in writing of the missing information or the verification problems and given 10 days to provide the requested information or verification.

1. **Household Income Criteria and Verification:** The evaluation of a patient's eligibility for the Financial Assistance program will be based upon a combination of the patient's household size and income (see Appendix B).
  - a. **Household size:** the number of family members or other persons occupying the same household who are identified as dependents for federal taxation purposes and any other individuals or significant others residing in the same household. This information will be self-reported and cannot be verified by requesting tax returns pursuant to NYS Department of Health Law 2807-k(9-a).
  - b. **Income:** annual earnings and cash benefits from all sources before taxes for the patient and anyone in the patient's defined household. Income shall include wages, interest, dividends, rents, pension, Social Security, VA benefits, unemployment benefits, worker's compensation, disability, child support, alimony and any other types of income that may accrue to the patient or any individual in the patient's defined household.
    - i. Income will be determined and verified based upon documentation of wages and/or other sources of income provided by the patient, such as pay stub or W2 (Tax returns or monthly bills cannot be requested under NYS Department of Health Law 2807-k(9-a)). Income may also be determined by annualizing the pay of the patient and others in the patient's defined household, at the current reported earnings rate.

2. **Household Assets Criteria and Verification:** Assets will not be taken into consideration when determining a patient's eligibility for Financial Assistance
3. **Additional Verification of Application Information:** The hospital will not seek any other sources of information outside of what is requested of and provided by the patient. The hospital will not perform credit checks or any other 3<sup>rd</sup> party verification to verify information provided by the patient on the Financial Assistance Application. Individuals cannot be denied financial assistance if they do not provide documentation that has not been specified in this FAP policy.

## **e – Application Determination**

A patient will be sent a written letter of determination within 30 days of the hospital's receipt of his or her completed application as to his or her eligibility for the Financial Assistance Program

## **f – Inquires**

Hospital may make inquiries to, and obtain reports, from third parties such as credit agencies, on certain patients to determine whether they may be presumptively eligible (presumptive eligibility) for Financial Assistance under the following limited conditions:

1. The patient has been discharged from the hospital
2. The patient lacks insurance coverage, the coverage has been exhausted, or all benefit coverage has been applied to the account
3. The patient has received a least one statement and the time period for paying that bill has expired, and
4. The patient has not completed an application for Financial Assistance.
5. Credit Scoring obtained will not negatively impact the patient's FICO.
6. Credit Scoring will not be used to deny financial assistance.

## **g – Appeal Process**

Any determinations made under this policy may be appealed in writing to Cayuga Health System, Chief Financial Officer, 101 Dates Drive, Ithaca, NY 14850.

## **h – Effective Dates of FAP Eligibility**

**Start Date:** The patient may apply for financial assistance any time during the collection process.

**Expiration:** From the date of approval, a patient's financial assistance application determination will be good for 12 months, at which time it will expire and the patient will have to reapply for future financial assistance. The patient will be provided with a card (see Appendix C) that will specify who is covered by the financial assistance application and what date their eligibility expires.

# **Section 3 - Provider Billing and Collection Efforts**

## **a – Billing**

Once a patient has submitted a completed application for the Financial Assistance Program, the patient may disregard any bill sent until the hospital has rendered a determination on the pending financial assistance application.

1. Billing statement must include a notice that financial assistance is available and provide a number and website to access more information about financial assistance
2. Installment payment plans may be established for patients who qualify for financial assistance. Monthly installment payments will be capped at 5% of gross monthly income of the patient's defined household.

## **b – Collections**

**Extraordinary Collections Actions (ECAs)** – including, but not limited to, reporting adverse information to credit bureaus or placing liens on property - cannot commence until at least 121 days after the 1<sup>st</sup> billing statement and requires that the patient be notified 30 days in advance with a pre-collect letter outlining what ECAs will occur and when.

Cayuga Health will not initiate lawsuits against patients with incomes below 400% of the Federal Poverty Level.

**Notification period:** The hospital will make a good faith effort to inform the patient financial assistance is available any time during the collection process. A patient cannot be sent to collection until the period has ended.

**Application period:** A patient will be allowed to apply for financial assistance any time during the collection process. If a patient submits an application at any point during the application period the following will occur:

1. Complete application
  - a. Suspend ECAs
  - b. Provide eligibility determination within 30 days
  - c. Send written letter of determination (see Appendix D & F)
  - d. Provide an updated billing statement reflecting adjusted amount due (if the patient ends up being FAP eligible)
2. Incomplete application
  - a. Suspend ECSs
  - b. Send written letter notifying patient that their application is pending and what information is needed to proceed with determining their eligibility (See Appendix E).

## **Section 4 – Updating, Execution, and Compliance**

### **a – Updates:**

The Compliance department, with assistance from and coordination with the Accounting Department & Patient Billing Department, will be responsible for updating this policy to meet the current needs of the hospital and regulatory requirements. Any substantive changes to the financial assistance policy must be approved and adopted by the Finance Committee of the hospital.

### **b- Execution**

The patient billing department and/or contractors in coordination of Financial Counselors will be responsible for executing this FAP and assisting patients in understanding this FAP.

### **c – Compliance Audit**

The Compliance Department with assistance from the Accounting and Patient Billing departments, will be responsible for completing an annual audit of the Financial Assistance Policy and Process to ensure the words of the policy and execution of the policy are in compliance with all relevant laws and regulations.





## **NYS Uniform Hospital Financial Assistance Application**

You may be eligible for hospital financial assistance to pay your bills if you are uninsured, if your insurance is exhausted, or if you have health insurance but have proof of paid medical expenses totaling more than 10% of your income. Completing this form will start your request for hospital financial assistance. This form is used by all hospitals in New York State.

*This application must be printed in the primary<sup>1</sup> languages spoken by patients served by the hospital.*

### **Patient Name (complete information that is applicable)**

Patient Name (First, Middle, Last)		
Date of Birth (mm/dd/yyyy)		
Address	Apartment/Unit #	
City	State	Zip
Contact Phone #		
Parent/Guardian or Lawful Representative Name (if patient is a minor child or an incapacitated adult)		
Email Address (if any)		

### **Family Information:**

Please list below all family members in your household. Your household includes yourself, your spouse or domestic partner, and any children or other dependents. For example, this would include everyone listed on the same tax return.

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).

Full Name	Relationship	Total Gross Income (Current)
	Self	

<sup>1</sup> "Primary languages" includes any language that is used to communicate in at least 5% of patient visits per year, or any language spoken by more than 1% of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems.

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The hospital may request you submit documentation as proof of income; examples of documentation might include a pay stub, a letter from your employer if applicable, or Form 1040.

### Health Insurance Status

Do you have any form of health insurance, including Medicaid, Medicare, or private insurance through your employer or purchased on your own? ☐ Yes ☐ No

If you answered "No," would you like assistance in applying for any of these programs?

☐ Yes ☐ No

**Underinsured patients: people with insurance and high medical expenses.** If you have insurance, please provide an estimate of the medical bills you paid in the past 12 months.

\$

The hospital may request you submit documentation as proof of paid medical expenses.

**Patient/Responsible Party:** If not the patient, list the name of the person signing the form and their authority to sign on behalf of the patient (e.g., spouse, parent, legal representative).

I understand that the information I submit may be subject to verification from external sources. I certify that the information is true and complete to the best of my knowledge.

Print Name	Date
Relationship to Patient	
Signature	

### Mail Completed Application to your location of Medical Care:

#### Cayuga Medical Center

Patient Accounting  
Attn: Financial Assistance  
101 Dates Drive  
Ithaca, New York 14850  
Hours: M-Th 8:00 a.m.-4:00 p.m.,  
F 8:00 a.m.-3:00 p.m.  
(607) 274-4400

#### Cayuga Medical Associates

Attn: Financial Aid  
PO Box 250  
Ithaca, New York 14851-0250  
Hours: M-F 8:00 a.m.-5:00 p.m.  
(607) 882-0010

#### Schuyler Hospital

Attn: Financial Counselor  
220 Steuben Street  
Montour Falls, New York 14865  
Hours: M-F 8:00 a.m.-4:00 p.m.  
(607) 535-8621 or (607) 535-8600

## Appendix B

### Cayuga Health System Financial Assistance Matrix

#### Family Size, Income Levels, and Sliding Discount Schedule

#### Uninsured

Discount	100%	100%	100%	100%	100%	10% of Medicaid Rate	10% of Medicaid Rate	20% of Medicaid Rate
Upper Limit of % of Federal Poverty Level	100%	125%	150%	175%	200%	250%	300%	400%
	100% or Below	101-125%	126 - 150%	151-175%	176-200%	201-250%	251 - 300%	301 - 400%
1	\$ 15,060.00	\$ 18,825.00	\$ 22,590.00	\$ 26,355.00	\$ 30,120.00	\$ 37,650.00	\$ 45,180.00	\$ 60,240.00
2	\$ 20,440.00	\$ 25,550.00	\$ 30,660.00	\$ 35,770.00	\$ 40,880.00	\$ 51,100.00	\$ 61,320.00	\$ 81,760.00
3	\$ 25,820.00	\$ 32,275.00	\$ 38,730.00	\$ 45,185.00	\$ 51,640.00	\$ 64,550.00	\$ 77,460.00	\$103,280.00
4	\$ 31,200.00	\$ 39,000.00	\$ 46,800.00	\$ 54,600.00	\$ 62,400.00	\$ 78,000.00	\$ 93,600.00	\$124,800.00
5	\$ 36,580.00	\$ 45,725.00	\$ 54,870.00	\$ 64,015.00	\$ 73,160.00	\$ 91,450.00	\$ 109,740.00	\$146,320.00
6	\$ 41,960.00	\$ 52,450.00	\$ 62,940.00	\$ 73,430.00	\$ 83,920.00	\$ 104,900.00	\$ 125,880.00	\$167,840.00
7	\$ 47,340.00	\$ 59,175.00	\$ 71,010.00	\$ 82,845.00	\$ 94,680.00	\$ 118,350.00	\$ 142,020.00	\$189,360.00
8	\$ 52,720.00	\$ 65,900.00	\$ 79,080.00	\$ 92,260.00	\$105,440.00	\$ 131,800.00	\$ 158,160.00	\$210,880.00
9	\$ 58,100.00	\$ 72,625.00	\$ 87,150.00	\$101,675.00	\$116,200.00	\$ 145,250.00	\$ 174,300.00	\$232,400.00
10	\$ 63,480.00	\$ 79,350.00	\$ 95,220.00	\$111,090.00	\$126,960.00	\$ 158,700.00	\$ 190,440.00	\$253,920.00
11	\$ 68,860.00	\$ 86,075.00	\$ 103,290.00	\$120,505.00	\$137,720.00	\$ 172,150.00	\$ 206,580.00	\$275,440.00
12	\$ 74,240.00	\$ 92,800.00	\$ 111,360.00	\$129,920.00	\$148,480.00	\$ 185,600.00	\$ 222,720.00	\$296,960.00
13	\$ 79,620.00	\$ 99,525.00	\$ 119,430.00	\$139,335.00	\$159,240.00	\$ 199,050.00	\$ 238,860.00	\$318,480.00
14	\$ 8,500.00	\$ 106,250.00	\$ 127,500.00	\$148,750.00	\$170,000.00	\$ 212,500.00	\$ 255,000.00	\$340,000.00

#### Under Insured

Discount	100%	100%	100%	100%	100%	10% of Patient Cost Share	10% of Patient Cost Share	20% of Patient Cost Share
Upper Limit of % of Federal Poverty Level	100%	125%	150%	175%	200%	250%	300%	400%
	100% or Below	101-125%	126 - 150%	151-175%	176-200%	201-250%	251 - 300%	301 - 400%
1	\$ 15,060.00	\$ 18,825.00	\$ 22,590.00	\$ 26,355.00	\$ 30,120.00	\$37,650.00	\$ 45,180.00	\$ 60,240.00
2	\$ 20,440.00	\$ 25,550.00	\$ 30,660.00	\$ 35,770.00	\$ 40,880.00	\$51,100.00	\$ 61,320.00	\$ 81,760.00
3	\$ 25,820.00	\$ 32,275.00	\$ 38,730.00	\$ 45,185.00	\$ 51,640.00	\$64,550.00	\$ 77,460.00	\$103,280.00
4	\$ 31,200.00	\$ 39,000.00	\$ 46,800.00	\$ 54,600.00	\$ 62,400.00	\$78,000.00	\$ 93,600.00	\$124,800.00
5	\$ 36,580.00	\$ 45,725.00	\$ 54,870.00	\$ 64,015.00	\$ 73,160.00	\$91,450.00	\$109,740.00	\$146,320.00
6	\$ 41,960.00	\$ 52,450.00	\$ 62,940.00	\$ 73,430.00	\$ 83,920.00	\$104,900.00	\$125,880.00	\$167,840.00
7	\$ 47,340.00	\$ 59,175.00	\$ 71,010.00	\$ 82,845.00	\$ 94,680.00	\$118,350.00	\$142,020.00	\$189,360.00
8	\$ 52,720.00	\$ 65,900.00	\$ 79,080.00	\$ 92,260.00	\$105,440.00	\$131,800.00	\$158,160.00	\$210,880.00
9	\$ 58,100.00	\$ 72,625.00	\$ 87,150.00	\$101,675.00	\$116,200.00	\$145,250.00	\$174,300.00	\$232,400.00
10	\$ 63,480.00	\$ 79,350.00	\$ 95,220.00	\$111,090.00	\$126,960.00	\$158,700.00	\$190,440.00	\$253,920.00
11	\$ 68,860.00	\$ 86,075.00	\$ 103,290.00	\$120,505.00	\$137,720.00	\$172,150.00	\$206,580.00	\$275,440.00
12	\$ 74,240.00	\$ 92,800.00	\$ 111,360.00	\$129,920.00	\$148,480.00	\$185,600.00	\$222,720.00	\$296,960.00
13	\$ 79,620.00	\$ 99,525.00	\$ 119,430.00	\$139,335.00	\$159,240.00	\$199,050.00	\$238,860.00	\$318,480.00
14	\$ 8,500.00	\$ 106,250.00	\$ 127,500.00	\$148,750.00	\$170,000.00	\$212,500.00	\$255,000.00	\$340,000.00



## Cayuga Health System Financial Assistance Program Card

For more information:

**Cayuga Medical Center**  
Patient Accounting  
(469) 322-4990 or  
billinghel@ cayugamed.org

**Cayuga Medical Associates**  
Financial Aid  
(607) 882-0010  
cayugamedicalassociates.org

**Schuyler Hospital**  
Financial Counselor  
(607) 535-8621 or (607) 535-8600  
schuylerhospital.org

**Appendix D**  
**Cayuga Health System Financial Assistance Program Acceptance Letter**

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Date

Patient Name

Street Address

City, State Zip

Dear Patient

Your application for financial assistance has been approved for the Cayuga Health System. Cayuga Health System includes Cayuga Medical Center, Schuyler Hospital and its Primary Care Clinics, Cayuga Medical Associates Affiliated Practices, Cayuga Addiction Recovery Services, Cayuga Health Transport, and Visiting Nurses Services.

**Per New York State statute you qualify for 100% financial assistance**

Enclosed you will find a Cayuga Health System Financial Assistance Program card which you should present at the time of registration at any of the locations listed above. Your card indicates all covered persons as well as the expiration date of the financial assistance. To reduce unnecessary reapplications to CHS FAP, an approved application will be in effect for 12 months from the date your eligibility determination was made.

You are required to contact the Cayuga Medical Center's Patient Billing Office at (607) 274-4400 if income levels, as reported on your application, change by \$5,000 or more, or if medical insurance is acquired. Failure to comply with this requirement may result in increased liability on previously adjusted accounts.

Please review your records and contact Cayuga Medical Center's Patient Billing Office at (607) 274-4400 if you believe you have prior accounts eligible for discount or with any questions you may have about the Cayuga Health System Financial Assistance Program.

Sincerely,

Cayuga Medical Center Appendix E  
**Cayuga Health System Financial Assistance Program Pending Letter**

Date

Applicant Name  
Street Address  
City, State, ZIP

Dear Applicant Name:

Cayuga Medical Center received your application on mm/dd/yyyy for the Cayuga Health System Financial Assistance Program. Your application is pending because we need the following information:

- ☐ Most Recent 3 months of Bank Statements
- ☐ Pay Stubs from 1 or More Household Earners
- ☐ Social Security Benefit & Investment Statements
- ☐ Unemployment Statement
- ☐ Worker's Compensation Statement
- ☐ Other: Based on current Medicaid guidelines, we believe you may qualify for Medicaid and we encourage you to apply while we process your application. You will not be denied if your Medicaid application is not processed within 30 days of this letter.

Please contact Cayuga Medical Center's Patient Billing Office at (607) 274-4400 with any questions. If the additional information is not received in 30 days from the date of this letter, your application will be denied. If you do not reapply or make payment arrangements, you will be responsible for 100% of your balance due.

Sincerely,