UR MEDICINE
FINANCIAL ASSISTANCE APPLICATION

Application Completed By: _____ Date: ____/____/____

Patient Name: _____ Patient Date of Birth: ___/___/___

Mailing Address: _____ Phone #: Home: ( ) _____

City, State, Zip _____

Home Address if different from mailing address: _____

Patient or Parent Employer: _____ Spouse or 2nd Parent Employer:_____

Number of members in the family: _____

Please list all household dependents including minor children under 21 who lives with you (even if they are not applying for Financial Assistance at this time. Use extra sheet if necessary.)

First and last name	Date of Birth	Relationship	Medical insurance

Medicaid Statement

I/We **([ ] have / [ ] have not)** applied for Medicaid, Child Health Plus, or other health insurance to cover these services.

If yes, please provide a copy of the notice received from the Department of Social Services or the NYS of Health Exchange programs.
If not, please explain why you have not applied or would you like assistance in applying for any of these programs?
_____

Return Form

PLEASE PROVIDE ANY OF THE AVAILABLE DOCUMENTATION BELOW THAT APPLY TO YOU:

- **Four current consecutive paystubs**
- **Social Security Income**
- **Pension Information**
- **Unemployment or workers compensation award letters**
- **Other documentation that explains current household gross income**
- **Federal Tax Return (This is not required, but helpful in making a determination of your application)**

RETURN TO:
Financial Assistance Officer
Strong Memorial Hospital
601 Elmwood Avenue – Box 888
Rochester, NY 14642

To meet with someone regarding the program you may visit our Financial Assistance Officer Monday – Friday from 9:00 a.m. to 3:00 p.m.:

Strong Memorial Hospital
601 Elmwood Ave
Room 1-2315
Rochester, NY 14642

Highland Hospital
1000 South Ave
Social Work Office, Room S213
Rochester, NY 14620

Your signature is required on page 2 of this application.

I understand that this application for Financial Assistance is confidential and will be used to determine my eligibility for uncompensated services under the Financial Assistance guidelines established by UR Medicine. If any information that has been given proves to be untrue, I understand that UR Medicine may re-evaluate my financial status and take whatever action becomes appropriate.

Signature of responsible party: _____
Date: _____

If you have any questions about completing this form, the Financial Assistance Officers can be reached at (585) 784–8889 or (800) 257-7049. Applications for the financial assistance program may take up to 30 days to be processed.

Thank you for your cooperation.

The following income guidelines may help determine if you are eligible for UR Medicine's Financial Assistance program. Applications may be submitted before, during, or after you receive care at UR Medicine. The intent of providing this information is to enable you to determine if you or your household may be eligible for this program. If you are in doubt, or if extenuating circumstances have occurred, we encourage you to submit this application for consideration. Other payment options may be available, even if you do not feel that your household qualifies for Financial Assistance. After a completed application has been submitted, bills may be disregarded while that application is being reviewed. During the review of a completed application bills will not be forwarded to a collection agency. If your application is turned down, the hospital will tell you why in writing and will provide you with a way to appeal this decision to a higher level within the hospital. <u>The following guidelines are effective 2/1/2017.</u>

<u>UR MEDICINE FINANCIAL ASSSISTANCE APPROVAL GUIDELINES</u>

Financial Assistance Allowance %	Household Size	% of FPL	One Person	Two Person	Three Person	Four Person	Five Person	Six Person
	Federal Poverty Level (FPL)		12,060	16,240	20,420	24,600	28,780	32,960
100%		up to 200%	24,120	32,480	40,840	49,200	57,560	65,920
80%		201 – 250%	30,150	40,600	51,050	61,500	71,950	82,400
60%		251 – 300%	36,180	48,720	61,260	73,800	86,340	98,880
40%		301 -350%	42,210	56,840	71,470	86,100	100,730	115,360
20%		351 - 400%	48,240	64,960	81,680	98,400	115,120	131,840
0		over 401%						
	Each additional household member add $4,160							

Example: A **one person** household with a gross annual income of $28,000 would receive a Financial Assistance allowance of **80%** as they would be below the 80% income limit of $30,150 but above the 100% income limit of $24,120.