NHSC

UR Medicine Affiliate Financial Assistance Application

The Financial Assistance Program provides assistance with medical bills for those who qualify.
To apply, complete the application and return with required documentation.

Date of Request:_____

Patient's Name:_____ DOB:_____

Phone (Home):_____ (Cell):_____

Mailing Address:_____

Guarantor Name:_____

Please list all household members including minor children under 21 that live with you (even if they are not applying for Financial Assistance at this time) if more space is required, use an additional sheet.

First and Last Name	Date of Birth	Relationship to Patient

If you are applying for Faith Based Assistance – Please check here ☐

You MUST include - Form 4029 Application for Exemption from Social Security and Medicare Waiver of Benefits

Income	Amount	Please indicate if this is weekly, monthly, etc.
Wages (includes self-employment)		
Social Security		
Unemployment Compensation		
Other * see list below - please indicate type		

Household Annual Income: $_____

Please return **copies** of the following documents with your completed Financial Assistance Application

- 1 month of wage/income statements
- If unemployed, please provide all sources of other income such as but not limited to:
  Unemployment Award Letter, Social Security/Disability Benefit Letter (Current year), etc.
- Other forms of income that may apply to you, please include proof of:
  **Alimony, Child Support, Military Family Allotments, Pensions/IRA/Retirement/Annuities, Income from Rent, Income from Dividends/Interest.*
- A copy of your most recent Income Tax Return which indicates Gross Income (this is not required but helpful in making a determination on your application)

- If you are Self-Employed- you MUST include a copy of most current Income Tax Return and a copy of the following forms that apply to your type of Self Employment Business:
    - First page of 1040; Net Profit or Loss from Business *(if applicable)*
    - Form 8825 Profit or Loss from Rental Income *(if applicable)*
    - Form 8825 Net Rental Real Estate Income *(if applicable)*

Please Note: Based on review of income, you may be asked to submit Medicaid Status Information.

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. I understand that this information may be used in discussions with another party to help determine eligibility.

X_____ Date_____

Signature of Person Making Request

The following income guidelines may help determine if you are eligible for UR Medicine Affiliate Financial Assistance Program. The intent of providing the following information is to enable you to determine if you or your household may be eligible for this program. If you are in doubt we encourage you to submit this application for consideration.

FINANCIAL ASSISTANCE APPROVAL GUIDELINES

2023 INCOME LEVELS							
Financial Assistance % Allowance	**% of Federal Poverty Level**	**1 Person**	**2 Person**	**3 Person**	**4 Person**	**5 Person**	**6 Person**
	Federal Poverty Levels (FPL)	**$ 14,580.00**	**$ 19,720.00**	**$ 24,860.00**	**$ 30,000.00**	**$ 35,140.00**	**$ 40,280.00**
100%	Up to 200%	$ 29,160.00	$ 39,440.00	$ 49,720.00	$ 60,000.00	$ 70,280.00	$ 80,560.00
80%	201% - 250%	$ 36,450.00	$ 49,300.00	$ 62,150.00	$ 75,000.00	$ 87,850.00	$ 100,700.00
60%	251% - 300%	$ 43,740.00	$ 59,160.00	$ 74,580.00	$ 90,000.00	$ 105,420.00	$ 120,840.00
40%	301% - 350%	$ 51,030.00	$ 69,020.00	$ 87,010.00	$ 105,000.00	$ 122,990.00	$ 140,980.00
20%	351% - 400%	$ 58,320.00	$ 78,880.00	$ 99,440.00	$ 120,000.00	$ 140,560.00	$ 161,120.00
0%	Over 401%						
Each additional household member add $5,140							
Example: A one person household with a gross annual income of $30,000 would receive a Financial Assistance allowance of **80%** as they would be below the 80% income of $36,450 but above the 100% income of $29,160							

Have questions or need help completing your application?
Please call and speak to one of our Customer Service Representatives:
(585)396-6515 or 1(833)978-8325

Please mail completed application and necessary documents to:

UR Medicine Affiliate Billing Office 73 Buffalo Street Suite 100, Canandaigua NY 14424

Incomplete applications will be returned unprocessed.

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