

**UNIVERSITY OF ROCHESTER MEDICAL CENTER  
STRONG MEMORIAL HOSPITAL  
Charity Care Application**

Application Completed By: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

*Please Mark Line N/A if non-applicable*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
 Responsible Person: \_\_\_\_\_  
 Spouse/Parent Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone #: Home: ( ) \_\_\_\_\_  
 \_\_\_\_\_ Work: ( ) \_\_\_\_\_  
 Employer: \_\_\_\_\_ Gross Salary: \$ \_\_\_\_\_ per \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Gross Salary: \$ \_\_\_\_\_ per \_\_\_\_\_  
 Number of people in the family \_\_\_\_\_  
 Other income including SSI/Social Security/Child Support payments:  
 Who receives income \_\_\_\_\_ Source \_\_\_\_\_ Gross amount \$ \_\_\_\_\_ per \_\_\_\_\_  
 Day Care Cost per child \_\_\_\_\_ Amount paid \$ \_\_\_\_\_ per \_\_\_\_\_

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

First and last name	Date of Birth	Relationship to you	Social Security Number	Medical insurance/ Cost

<b>Medicaid Statement</b>	<b>[ Please check the appropriate statement boxes. Attach copies of DSS notice including attachments.]</b>
	1. I/We ( <input type="checkbox"/> <b>have</b> / <input type="checkbox"/> <b>have not</b> ) applied for Medicaid to cover these services. If not, please explain reason: _____
	2. I/We ( <input type="checkbox"/> <b>have</b> / <input type="checkbox"/> <b>have not</b> ) been rejected by Medicaid. Reason for reject: Include a copy _____
	3. I/We ( <input type="checkbox"/> <b>have</b> / <input type="checkbox"/> <b>have not</b> ) been rejected by Child Health Plus or Family Health Plus _____
	4. I/We received an approval from Medicaid, but with a monthly spend down of \$ _____

The Strong Health Charity Care Program helps people who are unable to pay all of their medical bills. You may qualify for discounts on medical care through the Charity Care Program if:

- You do not have health insurance
- Your health insurance does not cover all of the medical care you need
- You are not eligible for Medicaid or some other type of insurance
- You meet the financial criteria

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

Signature of responsible party: \_\_\_\_\_  
Date: \_\_\_\_\_

***Please turn this form over, complete the items on the back, and return it.***

**Return  
Form**

**PLEASE PROVIDE COPIES OF THE FOLLOWING DOCUMENTS:**

- Wage/Income statements for the past 90 days
- Complete previous year's tax return
- Copy of insurance/Medicaid denial notices

**RETURN TO:**

**Charity Care Officer  
Strong Memorial Hospital  
601 Elmwood Avenue – Box 888  
Rochester, NY 14642**

If you have any questions about completing this form,  
I can be reached at (585) 784-8889 or (800) 257-7049

*Thank you for your cooperation.*

The following income guidelines may help determine if you are eligible for Strong Memorial Hospital's Charity Care program. 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 Charity Care. After a completed application has been submitted, bills may be disregarded while that application is being reviewed. (The following guidelines are effective 01/26/2009.

2009 CC Schedule

CC% Allowance	Household Size	% of FPL	One Person	Two Person	Three Person	Four Person	Five Person	Six Person
	FPL -Annual		\$10,830	\$14,570	\$18,310	\$22,050	\$25,790	\$29,530
	Monthly		903	1,214	1,526	1,838	2,149	2,461
100%		up to 200%	21,660	29,140	36,620	44,100	51,580	59,060
			1,805	2,428	3,052	3,675	4,298	4,922
80%		201 – 250%	27,075	36,425	45,775	55,125	64,475	73,825
			2,256	3,035	3,815	4,594	5,373	6,152
60%		251 – 300%	32,490	43,710	54,930	66,150	77,370	88,590
			2,708	3,643	4,578	5,513	6,448	7,383
40%		301 -350%	37,905	50,995	64,085	77,175	90,265	103,355
			3,159	4,250	5,340	6,431	7,522	8,613
20%		351 - 400%	43,320	58,280	73,240	88,200	103,160	118,120
			3,610	4,857	6,103	7,350	8,597	9,843
0		over 401%						

**For Office Use Only:**

Date Received in PAO: \_\_\_/\_\_\_/\_\_\_

By: \_\_\_\_\_

Approved By: \_\_\_\_\_

Rejected By: \_\_\_\_\_

Reason: \_\_\_\_\_  
\_\_\_\_\_

Applicant advised on \_\_\_/\_\_\_/\_\_\_ by [ ] phone [ ] letter [ ] in person.

An account for \$\_\_\_\_\_ for \_\_\_\_\_ payments established.