

**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 2<sup>nd</sup> 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

*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. The following guidelines are effective 2/1/2023.

**UR MEDICINE FINANCIAL ASSISTANCE APPROVAL GUIDELINES**

Financial Assistance Allowance %	Household Size	% of FPL	One Person	Two Person	Three Person	Four Person	Five Person	Six Person
	<b>FPL -Annual Gross Income</b>		<b>14,580</b>	<b>19,720</b>	<b>24,860</b>	<b>30,000</b>	<b>35,140</b>	<b>40,280</b>
100%		up to 200%	29,160	39,440	49,720	60,000	70,280	80,560
80%		201 – 250%	36,450	49,300	62,150	75,000	87,850	100,700
60%		251 – 300%	43,740	59,160	74,580	90,000	105,420	120,840
40%		301 -350%	51,030	69,020	87,010	105,000	122,990	140,980
20%		351 - 400%	58,320	78,880	99,440	120,000	140,560	161,120
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 limit of \$36,450 but above the 100% income limit of \$29,160.