Form #358 (02/20)

Financial Assistance Application

Application completed by: _____ Date: _____

Patient Name: _____ Patient DOB: _____

Mailing Address: _____ Phone #: _____

City, State, Zip: _____

Home Address, if different from mailing address: _____

Patient/Parent Employer: _____ Spouse/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 & Last Name	Date of Birth	Relationship	Medical Insurance	Monthly Income

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.

_____

If not, do you have a copy of IRS exemption from Medicare and Social Security Taxes under Section 3127 of the Internal Revenue Code? ☐ Yes ☐ No

Return Form

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

- Four current consecutive paystubs
- Pension information
- Social security income
- Unemployment or workers compensation award letters

Return to:

Financial Consultant
Jones Memorial Hospital
191 North Main Street
Wellsville, New York 14895

To meet with someone regarding the program, please call Monday-Friday from 9:00am to 3:00pm to make an appointment at (585) 596-4039 or (585) 596-4040

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 Jones Memorial Hospital. If any information that has been given proves to be untrue, I understand that Jones Memorial Hospital 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) 596-4039 or (585) 596-4040. 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 Jones Memorial Hospital's Financial Assistance program. Applications may be submitted before, during, or after you receive care at Jones Memorial Hospital. 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 2/1/2020

Financial Assistance Approved Guidelines

Financial Assistance Discount %	Household Size	% of FPL	One Person	Two Person	Three Person	Four Person	Five Person	Six Person
	FPL -Annual Gross Income							
5%		226 – 250%	31,225	42,275	53,325	64,375	75,425	86,475
25%		201-225%	28,102	38,047	47,992	57,937	67,882	77,827
45%		176-200%	24,980	33,820	42,660	51,500	60,340	69,180
65%		151-175%%	21,858	29,593	37,328	45,063	52,798	60,533
80%		126-150%	18,735	25,365	31,995	38,625	42,255	51,885
90%		101-125%	15,613	21,138	26,663	32,188	37,713	43,238
95%		</=100%	12,490	16,910	21,330	25,750	30,170	34,590
	Each additional household member add $4,420							

Example: A one person household with a gross annual income of $28,000 would receive a Financial Assistance discount of 5% as they would be below the 5% income limit of $31,225 but above the 25% income limit of $27,072.

For Jones Memorial Hospital Financial Consultant Use Only:

- ☐ Approved _____ Amount
- ☐ Denied _____ Reason
- ☐ Letter Sent _____ Date
- ☐ Added to spreadsheet _____ Date
- ☐ Database completed _____ Date

Financial Consultant : _____

191 North Main Street
Wellsville New York 14895
(585) 593-1100 / jones.urmc.edu