Financial Assistance Application
111 Clara Barton Street
Dansville, NY 14437
585-335-6001 Business or Credit Office

Application Completed By: _____ Date: _____

The Noyes Health Financial Assistance Program helps people who are unable to pay all of their medical bills. You may qualify for discounts on medical care through the Financial Assistance 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 and can verify income

Patient Name:	DOB:
Address:	City, State, Zip:
Phone:	Employer:
Spouse/Parent Name:	Spouse's Employer:
List Patient Account(s)	List Patient Account(s)
List Patient Account(s)	List Patient Account(s)
List Patient Account(s)	List Patient Account(s)

Please list all household members 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

	Patient Gross Income	Spouse Gross Income
Wages	_____	_____
Social Security	_____	_____
Unemployment Compensation	_____	_____
Disability/Workers Comp	_____	_____
Alimony/ Child Support	_____	_____
All Other Income	_____	_____

Verification of Income: W-2's, tax returns, copies of paychecks, unemployment/disability checks; SSI verification.

Please indicate the monthly amount you can afford toward your hospital bill? _____

Please check all the appropriate statement boxes. Attach copies of DSS notice including attachments.

1. I/We **(□ have / □ have not)** applied for Medicaid, Child Health Plus, or other health insurance to cover those services. If not, please explain reason: _____
2. I/We **have** been approved by Child Health Plus or health insurance product.

   Effective: _____
3. I/We **have** received an approval from Medicaid, but with a monthly spend down amount of $ _____.
4. I/We **have** been denied by Medicaid, Child Health Plus, or other health insurance. Reason for reject: **Please include a copy of denial with 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 Noyes Health. If any information that has been given proves to be untrue, I understand that UR Medicine may reevaluate my financial status and take whatever action becomes appropriate.

Signature of responsible party: _____ Date: _____

The following income guidelines may help determine if you are eligible for Noyes Health's Financial Assistance program. The intent of providing this information is to enable you to determine if you or your household may be eligible for this program. The following guidelines are effective as of March 2020

2020 INCOME LEVELS							
Financial Assistance % Allowance	% of Federal Poverty Levels	1 Person	2 Person	3 Person	4 Person	5 Person	6 Person
98%	0% - 99%	$12,760	$17,240	$21,720	$26,200	$30,680	$35,160
90%	100% - 150%	$19,140	$25,860,	$32,580	$39,300	$46,020	$52,740
80%	151% - 200%	$25,520	$34,480	$43,440	$52,400	$61,360	$70,320
70%	201% - 250%	$31,900	$43,100	$54,300	$65,500	$76,700	$87,900
60%	251% - 300%	$38,280	$51,720	$65,160	$78,600	$92,040	$105,480