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 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 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 2/1/2022.

UR MEDICINE FINANCIAL ASSSISTANCE APPROVAL GUIDELINES

Financial Assistance Allowance %	**Household Size**	**% of FPL**	**One Person**	**Two Person**	**Three Person**	**Four Person**	**Five Person**	**Six Person**
	FPL -Annual Gross Income		**13,590**	**18,310**	**23,030**	**27,750**	**32,470**	**37,190**
100%		up to 200%	27,180	36,620	46,060	55,500	64,940	74,380
80%		201 – 250%	33,975	45,775	57,575	69,375	81,175	92,975
60%		251 – 300%	40,770	54,930	69,090	83,250	97,410	111,570
40%		301 -350%	47,565	64,085	80,605	97,125	113,645	130,165
20%		351 - 400%	54,360	73,240	92,120	111,000	129,880	148,760
0		over 401%						
	Each additional household member add $4,720							

Example: A **one person** household with a gross annual income of $29,000 would receive a Financial Assistance allowance of **80%** as they would be below the 80% income limit of $33,975 but above the 100% income limit of $27,180.