UNIVERSITY OF ROCHESTER MEDICAL CENTER
STRONG MEMORIAL HOSPITAL
Charity Care Application

Application Completed By:_____ Date: ____/____/____

*Please Mark Line **N/A** if non-applicable* *MRN (For Office Use Only)*_____

Patient Name: _____ Date of Birth: ___/___/___
Address: _____ Income: $_____per_____
_____ Income: $_____per_____
Spouse/Parent Name: _____ Income Type_____
Phone #: Home: ( )_____
Responsible Person:_____ Citizenship (please check):
Employer: _____ U.S. Citizen ____
Spouse's Employer: _____ Immigrant/non-citizen____
Number of members in the family:_____ Non-immigrant Visa Holder____
Other____

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	Medical insurance/Cost	Citizenship

Medicaid Statement

[*Please check the appropriate statement boxes. Attach copies of DSS notice including attachments.]*

1. I/We (**[ ] have / [ ] have not)** applied for Medicaid to cover these services.
If not, please explain reason: _____

2. I/We (**[ ] have** / **[ ] have not**) been rejected by Medicaid.
Reason for reject: Include a copy _____

3. I/We **([ ] have/ [ ] have not**) 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:_____

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

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

Return Form

PLEASE PROVIDE COPIES OF THE FOLLOWING DOCUMENTS THAT ARE AVAILABLE:

- **Three current consecutive paystubs**
- **Federal Tax Return which indicates Adjusted Gross Income (This is not required, but helpful in making a determination of your application)**
- **Copy of insurance/Medicaid denial notices (if available)**

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

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. 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. (<u>The following guidelines are effective 01/28/2014.</u>

2014 CC Schedule

CC% Allowance	Household Size	% of FPL	One Person	Two Person	Three Person	Four Person	Five Person	Six Person
	FPL -Annual Gross Income		11,670	15,730	19,790	23,850	27,910	31,970
	Monthly Gross Income		973	1,311	1,649	1,988	2,326	2,664
100%		up to 200%	23,340	31,460	39,580	47,700	55,820	63,940
			1,945	2,622	3,298	3,975	4,652	5,328
80%		201 – 250%	29,175	39,325	49,475	59,625	69,775	79,925
			2,431	3,277	4,123	4,969	5,815	6,660
60%		251 – 300%	35,010	47,190	59,370	71,550	83,730	95,910
			2,918	3,933	4,948	5,963	6,978	7,993
40%		301 -350%	40,845	55,055	69,265	83,475	97,685	111,895
			3,404	4,588	5,772	6,956	8,140	9,325
20%		351 - 400%	46,680	62,920	79,160	95,400	111,640	127,880
			3,890	5,243	6,597	7,950	9,303	10,657
0		over 401%						
	Each additional 4060							

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.

Rev. 01/14ks