UPSTATE
MEDICAL UNIVERSITY

Date:_____

Dear _____:

Thank you for contacting Patient Financial Services. Our office will try to help you find programs you qualify for to help with your Upstate University Hospital bills. These services do not cover bills for outside providers or service groups. Our goal is to help you get the assistance you need and to work with you to pay your hospital bills.

Please fill out the form and application for financial assistance and return it to Upstate University Hospital at the address below within 20 days. We follow the New York State Charity Care Law and will help you as much as possible based on the guidelines. The New York State Charity Care Law of 2007 *(Public Health Law 2807-K)* requires the hospital to give you this information in a letter. Our office can help you with a payment plan if needed. Once you send an application to our office, hold off on paying any Upstate University Hospital bills until we respond.

You must include copies of the following for **all household members:**

- Proof of income including (2) current pay stubs for all employment.
- Pension Statement of Benefits.
- Social Security Statement of Benefits.
- Bank statements including checking and savings accounts - current (2) months. Include original documents for any other deposits listed on the statements.
- Most recent W-2's and/or 1099's for all employment.
- If self-employed, an income attestation and cash flow statement from an accountant/bookkeeper is required.

Please DO NOT send copies of state or federal tax returns.

We will process your application within 30 days of receipt of your completed application along with the above document request. After we process your complete application, we will notify you in writing the amount due to Upstate University Hospital. Your first installment payment or payment in full is due within 30 days from the date of the letter sent to you. We want to work with you to help you get your bills paid to the hospital.

Please call with any questions regarding this letter at (315) 464-8050.

Sincerely,

Upstate University Hospital
Financial Assistance Department

FINANCIAL EVALUATION/APPLICATION

Please Print

Name of Patient _____

Hospital Medical Record # ***Prescreening Not Completed***

Home Telephone Number _____ Work Telephone Number _____

Cell Telephone Number_____

Birth Date _____ Social Security Number _____

Home Address _____

Number & Street or PO Box Number_____

City _____ County _____ State _____ Zip Code _____

Please indicate marital status: ☐ Single ☐ Married ☐ Divorced

SPOUSE

Name of Spouse _____

Home Telephone Number _____ Work Telephone Number _____

Cell Telephone Number_____

Birth Date _____ Social Security Number _____

Home Address *(if different)* _____

Number & Street or PO Box Number_____

City _____ State _____ Zip Code _____

If the patient was under 18 years of age at the time of treatment, please complete Responsible Party Information (below). This includes information on step parents pursuant to Social Services Law §101(c).

RESPONSIBLE PARTY INFORMATION *(PARENTS, STEP-PARENTS, OR OTHER)*

Name of Responsible Party #1 _____

Relationship to Patient _____

Address *(if different from patient's)* _____

Number & Street or PO Box Number_____

City _____ State _____ Zip Code _____

Birth Date _____ Social Security Number _____

Home Telephone Number _____ Work Telephone Number _____

Cell Telephone Number_____

Name of Responsible Party #2 _____

Relationship to Patient _____

Address *(if different from patient's)* _____

Number & Street or PO Box Number _____

City _____ State _____ Zip Code _____

Birth Date _____ Social Security Number _____

Home Telephone Number _____ Work Telephone Number _____

Cell Telephone Number _____

FAMILY/HOUSEHOLD MEMBER INFORMATION *(LIST ALL HOUSEHOLD MEMBERS INCLUDING PATIENT)*

Name	Relationship to Patient	Age	Employed	F/T or P/T Student
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

GROSS FAMILY INCOME

Name of Family Member	Source of Income	Name of Employer	Gross $ Per Week

Income Verification/Documentation required for all household members as follows:

- Proof of income including (2) current pay stubs for all employment.
- Pension Statement of Benefits.
- Social Security Statement of Benefits.
- Bank statements including checking and savings accounts - current (2) months. Include original documents for any other deposits listed on the statements.
- Most recent W-2's and/or 1099's for all employment.
- If self-employed, an income attestation and cash flow statement from an accountant/bookkeeper is required.

Please DO NOT send copies of state or federal tax returns.

OTHER INCOME *(PLEASE MARK WHERE APPLICABLE)*

Furnish copy of monthly *benefit statement* for income sources marked.

- ☐ Social Security or State Disability
- ☐ Public Assistance
- ☐ Company Pension
- ☐ Veteran Benefits
- ☐ Interest
- ☐ Alimony
- ☐ Child Support
- ☐ Unemployment
- ☐ Worker's Compensation
- ☐ Other _____

Amount received per month: _____

I hereby certify that all of the information contained herein is true and correct and the documentation submitted as to earnings, account(s), marital status and dependents is true and accurate to the best of my knowledge and belief.

Please be advised that the information you have provided will be used solely for the purpose of compliance with the New York State Charity Care Law of 2007 (Public Health Law §2807-K).

I will furnish any additional information which may be required. I will report immediately any changes in circumstances, including financial resources. I will assist in filing or file any claims for health and accident insurance benefits to which I am entitled and I will make any required assignment of such benefits to State University of New York Upstate Medical University.

If requesting a Financial Reduction, I understand that I must comply with all State and Federal requirements for eligibility.

PENDING LEGAL ACTION

Are there any pending legal actions on your behalf?

☐ Yes ☐ No

If yes, please explain below and provide your attorney's name, phone number, and address.

_____

_____

_____

_____

Patient's Signature _____ **Date** _____

If Patient is a minor under 18 years of age at time of service, signature of Responsible Party(s) is required:

Responsible Party Signature _____ Date _____

If requesting a financial reduction, I understand that I must comply with all State and Federal requirements for eligibility.

Please mail Financial Evaluation/Application and requirements to:

Upstate University Hospital
Fiscal Services Division
750 E. Adams St.
Syracuse, NY 13210

If you have any questions in regards to completing this application, feel free to contact (315) 464-8050.