FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____ **Date of Birth:** _____

Address: _____

Number/Street *City* *State* *Zip*

Contact Telephone Numbers: (*Please provide all applicable contact numbers)*

Home: _____ **Work:** _____ **Cell:** _____

Family Size: _____ **Occupation:** _____

Current Employer: _____

Please List Other Family Members

NAME	RELATIONSHIP	DATE OF BIRTH

Medicaid/Other Insurance Statement

I/We ([ ] have [ ] have not) applied for Medicaid, Child Health Plus, or other insurance to cover these services.

If yes, please provide copy of the notice received from the Department of Social Services or the NYS of Health Exchange programs.

Would you like assistance in applying for any of these programs? [ ] Yes [ ] No

*Note: INCOMPLETE APPLICATION WILL BE RETURNED UNPROCESSED

I certify that the information is true and accurate to the best of my knowledge. I understand that this application is made so that Orleans Community Health can judge my eligibility for Financial Assistance benefits as related to New York State Guidelines.

_____ _____

Signature *Date*

Please send completed application by fax to (585)798-8444or by mail to: Orleans Community Health, Attn: Patient Accounting Department, 200 Ohio Street, Medina, NY 14103or drop application off at Medina Memorial Hospital switchboard or business office

Please turn over and complete page 2

The following income information is mandatory for application to be reviewed. List all forms of income, both earned and unearned for all family members listed on the application. Family members include only those listed on the Federal Tax Return.

Types of Income

Wages and Salary
- Pay Stubs
- Current Income Tax Return

Self-Employment
- Current Income Tax Return
- Records Earnings/Expenses

Unemployment Benefits
- Award Letter
- Monthly Benefit statement
- Correspondence from NYS Dept of Labor

Private Pensions/Annuities
- Statement from pension/annuity

Social Security
- Award Letter
- Annual Benefit Statement

Worker's Compensation
- Award Letter
- Check Stub

Child Support/Alimony
- Letter person providing support
- Letter from court
- Child support/alimony check stub
- Copy of bank statement showing direct deposit

Veteran's Benefits
- Award Letter
- Check stub
- Correspondence from VA

Military Pay
- Award Letter
- Check Stub

Income from Rent
- Recent Bank Statement
- 1099 or Tax Return

Interest/Dividends
- Recent bank statement
- Letter from broker/agent
- 1099 or tax return

PROOF OF HOUSEHOLD INCOME IS REQUIRED.

NAME OF PERSON	TYPE OF INCOME	GROSS INCOME (before taxes)	RECEIVED (weekly,monthly,etc)

The following guidelines may help you to determine if you are eligible. The lookback will be one year from the date of the application and will expire one year from application date. If you receive a bill after you have turned in your application, you can disregard it until a decision has been made on you application. Even if you do not feel that your household qualifies, there may be other payment options available. The following guidelines are effective January 16, 2023.

up to 150%	151% to 200%	201% to 250%	251% to300%	301% to400%	Over 401%
100%	80%	60%	40%	20%	0%

Family Size	100% Guideline*	150% Guideline	200% Guideline	250% Guideline	300% Guideline	400% Guideline
1	**$14580**	**$21870**	**$29160**	**$36450**	**$43740**	**$58320**
2	**$19720**	**$29580**	**$39440**	**$49300**	**$59160**	**$78880**
3	**$24860**	**$37290**	**$49720**	**$62150**	**$74580**	**$99440**
4	**$30000**	**$45000**	**$60000**	**$75000**	**$90000**	**$120000**
5	**$35140**	**$52710**	**$70280**	**$87850**	**$105420**	**$140560**
6	**$40280**	**$60420**	**$80560**	**$100700**	**$120840**	**$161120**
7	**$45420**	**$68130**	**$90840**	**$113550**	**$136260**	**$181680**
8	**$50560**	**$75840**	**$101120**	**$126400**	**$151680**	**$202240**

***Add $5140 for each person in household over 8**