ROCHESTER REGIONAL HEALTH

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Patient's Name _____ (First) _____ (Last) _____ (MI) _____ (Date of Birth)

Responsible Party _____ (First) _____ (Last) _____ (MI)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Phone _____ Household Size _____

Household Information

Please list everyone who lives with you, even if they are not applying for assistance.
Place a √ checkmark before each name below to indicate who is applying for Financial Assistance.

Applying for Financial Assistance	Name	Date of Birth	Relationship to Patient
☐			
☐			
☐			
☐			
☐			
☐			

Medicaid / Other Insurance Statement

1. I/We ☐ have / ☐ have not applied for Medicaid, Child Health Plus, or other health insurance to cover these services.

   If not, please explain reason: _____.

2. Please explain reason for financial hardship: _____

   _____

PLEASE TURN OVER / COMPLETE PAGE TWO (2) OF THE APPLICATION

DO NOT COPY IN PATIENT'S CHART

Mail application to: Rochester Regional Health, Attn: Financial Assistance, 100 Kings Highway South, Rochester, NY 14617
Email: financialaid@rochesterregional.org **Fax:** 585-922-1341

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Types of Income

Wages and Salary
- Paycheck Stubs
- Letter from employer on company letterhead, signed and dated
- Current signed and dated income tax return and all Schedules
- Business/payroll records

Self-Employment
- Current signed and dated income tax return and all Schedules
- Records of earnings and expenses/business records

Unemployment Benefits
- Award letter / certificate
- Monthly benefit statement from NYS Department of Labor
- Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us)
- Copy of Direct Payment Card with printout
- Correspondence from the NYS Department of Labor

Social Security (Retirement / Disability)
- Award letter / certificate
- Annual benefit statement
- Correspondence from Social Security Administration

Worker's Compensation
- Award letter
- Check stub

Child Support / Alimony
- Letter from person providing support
- Letter from court
- Child support/alimony check stub
- Copy of NY Epicard with printout
- Copy of child support account information from www.newyorkchildsupport.com
- Copy of bank statement showing direct deposit

Military Pay
- Award letter
- Check stub

Income from Rent or Room/Board
- Letter from roomer, boarder, tenant
- Check stub

Interest/Dividends/Royalties
- Recent statement from bank, credit union or financial institution
- Letter from broker
- Letter from agent
- 1099 or tax return (if no other documentation is available)

Private Pensions/Annuities
- Statement from pension / annuity

Veteran's Benefits
- Award letter
- Benefit check stub
- Correspondence from Veterans Affairs

Household Income

Proof of household income is required. Please write in the amount and type of monies received by all members of the Household listed on Page 1 and attach proof of income with the completed application.

Name of Person	Type of Income (see above)	Gross Income Amount (Before Taxes)	Received how often? (Weekly, Monthly, etc.)

I certify the above information is true and accurate to the best of my knowledge. I will cooperate with any assistance which may be available for coverage regarding payment of my hospital charges.. If any information I have given proves to be false, I understand Rochester Regional health may re-evaluate my financial status and take whatever action becomes appropriate.

Signature of Patient or Responsible Party:_____ Date: _____

Please allow 30 days for application to be processed.

Once a patient has submitted a completed application for a Financial Assistance Discount, the patient may disregard any bill from Rochester Regional Health that might be sent until such time as Rochester Regional Health has rendered a determination on the pending application.