



Financial Assistance Program  
 Financial Counseling Services  
 462 Grider Street, Room G-4  
 Buffalo, NY 14215  
 Office: 716-898-5566 Fax: 716-898-4338

**PROCESS FOR APPLYING FOR ERIE COUNTY MEDICAL CENTER CORPORATION  
 FINANCIAL ASSISTANCE PROGRAM**

To qualify for the financial assistance program, you must complete the application and provide necessary documentation. You may be contacted by a financial counselor for financial screening and to enroll in a government funded program if eligible. We will be happy to assist you in completing and filing the application.

Note: If your application for Medicaid or Family Health Plus is denied because you did not submit all of the information they require, your request for the financial assistance program will also be denied.

**To apply, see if you meet the qualifications below**

FAMILY SIZE	ASSET LEVEL  Considered only for applicants with gross income between 151% and 400% of the FPL	FEDERAL POVERTY LEVEL	GROSS INCOME ELIGIBILITY SCALE			
			150% or less (Level 1)	151%-250% (Level 2)	251%-350% (Level 3)	351%-400% (Level 4)
			<b>Inpatient Services Patient Share</b>			
			0%	20%	50%	75%
			<b>Outpatient Services Patient Share</b>			
			0%	15%	20%	25%
<b>1</b>	13,800	10,890	16,335	27,225	38,115	43,560
<b>2</b>	20,100	14,710	22,065	36,775	51,485	58,840
<b>3</b>	23,115	18,530	27,795	46,325	64,855	74,120
<b>4</b>	26,130	22,350	33,525	55,875	78,225	89,400
<b>5</b>	29,145	26,170	39,255	65,425	91,595	104,680
<b>6</b>	32,160	29,990	44,985	74,975	104,965	119,960
<b>7</b>	35,175	33,810	50,715	84,525	118,335	135,240
<b>8</b>	38,190	37,630	56,445	94,075	131,705	150,520
<b>9</b>	41,205	41,450	62,175	103,625	145,075	165,800
<b>10</b>	44,220	45,270	67,905	113,175	158,445	181,080

**Income guidelines effective 4/1/11-3/31/12 unless modified prior to 3/31/12.**



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**Submit all of the following items with your application within 90 days of date of service.**

- A. Last 2 weeks pay check stubs, unemployment checks or other verifiable proof of income from any other source including disability, pension, etc. for all family members you are counting as members of your household. For those self employed, please include a three (3) month business ledger.
- B. Written denial and Budget Sheet for Medicaid coverage from the Department of Social Services.
- C. If unable to verify income you may include a self attestation of income that is signed and witnessed by a notary or commissioner of deeds.
- D. If your income exceeds 150% of the Federal Income Poverty Guidelines please submit copies of current statements for all bank accounts, CDs, stocks, mutual funds, or any other financial account(s). Retirement & education accounts are not considered.
- E. Photo identification.
- F. Proof of address.
- G. Marriage certificate or divorce decree.

After all items are received, your request will be reviewed. You will be notified in writing within 30 days of our determination. Please disregard any bills until you have received the decision. Financial Assistance discounts may be awarded on unpaid medically necessary services up to 90 days prior to the date of service.

The Financial Assistance Program features an Economic Hardship provision that can become operative when a patient confronts substantial hospital charges. Use of the Economic Hardship provision potentially may allow clients to participate in the Financial Assistance Program who otherwise would not be eligible due to income and/or resource levels which exceed the standard program guidelines or non New York State or Northern Pennsylvania residency. This provision may also qualify a program applicant who due to unforeseen circumstances failed to apply for program coverage within ninety (90) days from the date of service or thirty (30) days from the date of a Medicaid determination. Persons applying for the Economic Hardship exemption can do so on the prescribed standard application.

**IMPORTANT - The Financial Assistance program does not cover Medicaid Spend down, prescriptions, level 2 dental procedures (dentures, partials, root canals, implants, etc.), private physician charges (radiologist, anesthesiologist, etc.), elective non-medically necessary procedures, court-mandated treatment for drinking drivers and subsequent follow-up, private room differentials trays, or telephone/television charges.**

The provisions of this program are subject to change and may include additional policy provisions that pertain to issues that were unforeseen at the time the Financial Assistance Program was first implemented.

You may fax your information to Financial Counseling at (716) 898-4338 or mail information to:

ECMCC - Financial Assistance Program  
Financial Counseling Services  
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## APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM

List names & dates of birth for all family members living in the household. Proof of date of birth and relationship must be submitted.

Last Name	First Name	D.O.B

Address:

Home Phone:

Cell phone:

**IF INCOME EXCEEDS 150% OF THE FEDERAL POVERTY GUIDELINES LIST ASSETS OF ALL HOUSEHOLD MEMBERS:**

List all bank accounts (exclude retirement accts)  
 Attach copies of current statement (s)

**Bank Accts:**

Checking Acct#: \_\_\_\_\_  
 Bank Name: \_\_\_\_\_  
 Balance: \_\_\_\_\_  
 Savings Acct#: \_\_\_\_\_  
 Bank Name: \_\_\_\_\_  
 Balance: \_\_\_\_\_

**HOUSEHOLD MONTHLY INCOME FOR ALL INDIVIDUALS IN THE HOUSEHOLD:**

List all income amounts combined and attach copies of income.

Wages: \_\_\_\_\_  
 Social Security: \_\_\_\_\_  
 Disability: \_\_\_\_\_  
 Unemployment: \_\_\_\_\_  
 Child Support: \_\_\_\_\_  
 Pension: \_\_\_\_\_  
 Alimony: \_\_\_\_\_  
 Dividends, Interest: \_\_\_\_\_  
 Rental Income: \_\_\_\_\_  
 Other Income: \_\_\_\_\_

Did you apply for Medicaid or Family Health Plus? Yes  No   
 If yes, Please provide proof of eligibility or denial.



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I certify that the information provided in this application is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which maybe available for payment of my hospital charges, and will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can judge my eligibility under the Erie County Medical Center Corporation Charity Care Policy. If any information I have given is untrue, I understand that the hospital may re-evaluate my financial status and take whatever action deemed appropriate.

I agree to provide additional information as requested in order to determine eligibility. I agree to inform Erie County Medical Center Corporation of any changes in my needs, insurance eligibility, income, and living arrangements and/or address as they occur.

I understand that I have 90 days from the date of service to submit a financial assistance application.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Revision 5/11/2011