Revision Date June 2013

**Erie County Medical Center**

Financial Assistance Application

Patient Name: _____ Patient # (MRN): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Guarantor/Head of Household: _____

**Patient Account Registration Details**

*(to be completed by the Financial Counselor or Liaison)*

| Account Reg. # | Date of Admission | Account Reg. # | Date of Admission |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Application Date: _____ Total Account Charges as of: _____ Amount: _____

Total Balance Due as of: _____ Amount: _____

**Household Members**

*Please provide the full name and date of birth for all members. Please include Social Security Number and relationship, if known.*

*Household Members Name, Date of Birth & Relationship to Applicant (Patient) is Required*

| Name | Date of Birth | Social Security Number | Relationship to Applicant |
|---|---|---|---|
| | | | Self |
| | | | |
| | | | |
| | | | |
| | | | |

**Household Income Information**

*Include all sources of income (wages). Only earned income should be noted here.*

| Household Member | Employer & Location *(Address if available)* | Amount | Period | Start Date | End Date *(If Applicable)* |
|---|---|---|---|---|---|
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Total Household Income – Monthly (Gross): _____

| **Unearned Income**<br>*Unearned income such as Social Security benefits, Alimony, Child Support, Pension, Retirement, etc should be listed here.* | | | |
|---|---|---|---|
| **Household Member** | **Unearned Income Type** | **Amount** | **Period** |
| | | | |
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| | | | |
| | | | |

| **Assets/Resources**<br>*Please provide details about all Assets/Resource for the household.* | | | |
|---|---|---|---|
| **Household Member** | **Asset/Resource Type** | **Value** | **Additional Account Holder(s)** *(If Applicable)* |
| | | | |
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| | | | |
| | | | |

| **Health Insurance**<br>*Please provide information on any CURRENT health insurance or state program (ie, Medicaid, CHP, Medicare, FHP, etc) Please include policy numbers and note which household members are covered if applicable.* | | | | |
|---|---|---|---|---|
| **Policy Holder Name** | **Policy Name Or State Program Name** | **Address** *(If Known/Applicable)* | **Policy Number** | **Household Members covered under Policy** |
| | | | | |
| | | | | |
| | | | | |

You may disregard ECMC bills that you receive while an application for financial assistance is pending.

I affirm that the above information is true, complete, and correct to the best of my knowledge:

Applicant's Signature: _____ Date: _____

Authorized Representative Name: _____

Authorized Representative Signature: _____ Date: _____

Financial Counselor Name: _____ Phone #: _____

Notes: