Revision Date September 2019

**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 (Optional) | 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** |
| | | | |
| | | | |
| | | | |
| | | | |

| **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 #: _____

462 Grider St Buffalo NY 14215
Attn: Financial Counseling

Patient Name _____

Date: _____

Thank you for choosing Erie County Medical Center Corporation (ECMCC) as your choice for Medical Services. We strive for excellence in every service we provide. Our records indicate that you had a recent visit to our facility and that you may not have health insurance or you have high co-pay/deductible. ECMCC has a Financial Assistance program that can significantly reduce your out of pocket expenses. Please note the following:

____ You may be eligible for Medicaid or Financial Assistance to cover your hospital bills. Please call 716-898-5566 to learn more.

____ You want to apply for Medicaid and/or financial assistance. Your application cannot be processed without the following required documentation. Please review the list of required documents to complete the initial application process.

Please provide us with the following documentation for all members of your household, so that we may process and/or submit your application(s). If you are submitting an application, all of these items are required.

____ Proof of identity/citizenship – You must provide photo ID or one of the following items:

- Birth Certificate
- Permanent Resident Card
- Naturalization Paperwork
- Refugee Paperwork
- Social Security Card
- Native American Tribal Documentation

____ Proof of Residency; may be one of the following items:

- Landlord statement or lease agreement
- Postmarked mail in your name
- Deed/mortgage statement or tax statement

462 Grider St Buffalo NY 14215
Attn: Financial Counseling

Patient Name: _____
Date: _____

____ Proof of income and/or support

- Verification of all monies received (pay-stubs, tax return, letter from your employer)
- Social Security Award letter, notice of pension
- Verification of Support if you have no earned income (letter from person supporting you)
- Verification of Self-Employment income (three month ledger)

For any questions regarding this application process, please contact our Financial Counseling Department at (716) 898-5566