ECMC
462 Grider St Buffalo NY 14215
Attn: Financial Counseling

Erie County Medical Center
Patient Financial Services

Patient Name: _____
Date: _____
MRN: _____

_____

Dear

Thank you for choosing 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. ECMC 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 have applied for Medicaid and/or financial assistance, but your application cannot be processed as we have not received all of the 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 be process and/or submit your application(s). If you have a previous application in process, the missing documents are checked off. If you have not yet submitted an application or documentation, 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

____ 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)

____ Miscellaneous Items *(if these apply to you and your household)*:
- Verification of insurance and premiums
- Proof of child care expenses
- Copies of medical bills
- Verification of disability

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Notes:

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 (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)*

Total Household Income – Monthly (Gross): _____

Erie County Medical Center
Financial Assistance Application

Unearned Income *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 *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 #: _____

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Authorized Representative Name: _____

Authorized Representative Signature: _____ Date: _____

Financial Counselor Name: _____ Phone #: _____