UPSTATE
UNIVERSITY HOSPITAL

FINANCIAL EVALUATION/APPLICATION OUTPATIENT PHARMACY

Please Print

Name of Patient _____

Hospital Medical Record # ***Prescreening Not Completed***

Home Telephone Number _____ Work Telephone Number _____

Cell Telephone Number _____

Birth Date _____ Social Security Number _____

Home Address _____

Number & Street or PO Box Number _____

City _____ County _____ State_____ Zip Code _____

Please indicate marital status: ☐ Single ☐ Married ☐ Divorced

SPOUSE

Name of Spouse _____

Home Telephone Number _____ Work Telephone Number _____

Cell Telephone Number _____

Birth Date _____ Social Security Number _____

Home Address *(if different)* _____

Number & Street or PO Box Number _____

City _____ State _____ Zip Code _____

If the patient was under 18 years of age at the time of treatment, please complete Responsible Party Information (below). This includes information on stepparents pursuant to Social Services Law §101(c).

RESPONSIBLE PARTY INFORMATION *(PARENTS, STEPPARENTS, OR OTHER)*

Name of Responsible Party #1 _____

Relationship to Patient _____

Address *(if different from patient's)* _____

Number & Street or PO Box Number _____

City _____ State _____ Zip Code _____

Birth Date _____ Social Security Number _____

Home Telephone Number _____ Work Telephone Number _____

Cell Telephone Number _____

Name of Responsible Party #2 _____

Relationship to Patient _____

Address *(if different from patient's)* _____

Number & Street or PO Box Number _____

City _____ State _____ Zip Code _____

Birth Date _____ Social Security Number _____

Home Telephone Number _____ Work Telephone Number _____

Cell Telephone Number _____

FAMILY/HOUSEHOLD MEMBER INFORMATION *(LIST ALL HOUSEHOLD MEMBERS INCLUDING PATIENT)*

Name	Relationship to Patient	Age	Employed	F/T or P/T Student
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

GROSS FAMILY INCOME

Name of Family Member	Source of Income	Name of Employer	Gross $ Per Week

Income Verification/Documentation required for all household members as follows:

- Proof of income including (2) current pay stubs for all employment.
- Pension Statement of Benefits.
- Social Security Statement of Benefits.
- Bank statements including checking and savings accounts - current (2) months. Include original documents for any other deposits listed on the statements.
- Most recent W-2's and/or 1099's for all employment.
- If self-employed, an income attestation and cash flow statement from an accountant/bookkeeper is required.

Please DO NOT send copies of state or federal tax returns.

OTHER INCOME *(PLEASE MARK WHERE APPLICABLE)*

Furnish copy of monthly *benefit statement* for income sources marked.

☐ Social Security or State Disability ☐ Alimony

☐ Public Assistance ☐ Child Support

☐ Company Pension ☐ Unemployment

☐ Veteran Benefits ☐ Worker's Compensation

☐ Interest ☐ Other _____

Amount received per month: _____

I hereby certify that all of the information contained herein is true and correct and the documentation submitted as to earnings, account(s), marital status and dependents is true and accurate to the best of my knowledge and belief.

Please be advised that the information you have provided will be used solely for the purpose of compliance with the New York State Charity Care Law of 2007 (Public Health Law §2807-K).

I will furnish any additional information, which may be required. I will report immediately any changes in circumstances, including financial resources. I will assist in filing or file any claims for health and accident insurance benefits to which I am entitled and I will make any required assignment of such benefits to State University of New York Upstate Medical University.

If requesting a Financial Reduction, I understand that I must comply with all State and Federal requirements for eligibility.

PENDING LEGAL ACTION

Are there any pending legal actions on your behalf?

☐ Yes ☐ No

If yes, please explain below and provide your attorney's name, phone number, and address.

_____

_____

Patient's Signature _____ **Date** _____

If Patient is a minor under 18 years of age at time of service, signature of Responsible Party(s) is required:

Responsible Party Signature _____ Date _____

If requesting a financial reduction, I understand that I must comply with all State and Federal requirements for eligibility.

Please mail Financial Evaluation/Application and requirements to:

Upstate University Hospital
Medication Assistance Coordinator
250 Harrison St, 6th floor
Syracuse, NY 13202
UpstateMedHelp@upstate.edu
315-464-4221 (Fax)

If you have any questions in regards to completing this application, feel free to contact (315) 464--9862