



## FINANCIAL EVALUATION/APPLICATION OUTPATIENT PHARMACY

Please Print

Name of Patient \_\_\_\_\_

Medical Record Number (MRN) \_\_\_\_\_

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
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

- |  |  |
|--|--|
| <input type="checkbox"/> Social Security or State Disability | <input type="checkbox"/> Alimony               |
| <input type="checkbox"/> Public Assistance                   | <input type="checkbox"/> Child Support         |
| <input type="checkbox"/> Company Pension                     | <input type="checkbox"/> Unemployment          |
| <input type="checkbox"/> Veteran Benefits                    | <input type="checkbox"/> Worker's Compensation |
| <input type="checkbox"/> Interest                            | <input type="checkbox"/> 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 send completed forms and supporting documents via fax, email, or postal mail to:***

**For office use only:**

Signature of Medication Assistance  
Coordinator receiving Financial Application:

X \_\_\_\_\_

Upstate University Hospital- Outpatient Pharmacy  
Medication Assistance Coordinator  
750 E Adams St, Syracuse, NY 13210  
Syracuse, NY 13202  
[UpstateMedHelp@upstate.edu](mailto: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**