State University of New York
UPSTATE
OUTPATIENT PHARMACY

Financial Evaluation & Application

(Please Print)

Name of Patient: _____

Email Address: _____ Home Phone No.:_____

Work Phone No.: _____ Cell Phone No.: _____

Birth Date:_____ Social Security Number: _____

Home Address: _____

City: _____ County: _____State: _____ Zip Code:_____

Would you like to participate in our text to renewal program? This program will send you a direct text message and alert you when your financial assistance is due for renewal. This will also allow you to renew directly from your cell phone. ☐ Yes ☐ No

Please indicate your preferred method of contact: ☐ Email ☐ Text ☐ Phone Call ☐ U.S. Postal Mail

Please indicate marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse/Significant Other Information:

Name of Spouse/Significant Other: _____

Home Phone No.:_____Work Phone No.:_____

Cell Phone Number: _____

Birth Date: _____Social Security Number: _____

Home Address *(if different than patient)* _____

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: _____

Home Phone No.:_____Work Phone No.:_____

Cell Phone Number: _____

Birth Date: _____Social Security Number: _____

Home Address *(if different than patient)* _____

City: _____ State: _____ Zip Code:_____

Responsible Party Information (Parents, Stepparents, or Other)
(continued)

Name of Responsible Party #2: _____

Relationship to Patient: _____

Home Phone No.:_____Work Phone No.:_____

Cell Phone Number: _____

Birth Date: _____Social Security Number: _____

Home Address *(if different than patient)* _____

City: _____ State: _____ Zip Code:_____

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	

Family/household Income

Name of Family Member	Source of Income	Name of Employer	Please check box that best applies
			☐ Weekly ☐ BiWeekly ☐ Monthly ☐ Annually
			☐ Weekly ☐ BiWeekly ☐ Monthly ☐ Annually
			☐ Weekly ☐ BiWeekly ☐ Monthly ☐ Annually
			☐ Weekly ☐ BiWeekly ☐ Monthly ☐ Annually

Income verification/documentation required for all household members. Acceptable forms of verification/documentation are:

- Proof of income including (2) current pay stubs for all employment
- Pension Statement of Benefits
- Social Security Statement of Benefits
- Annuity
- If self-employed, an income attestation and cash flow statement from an account/bookkeeper is required. Schedule C or F AND 1040.
- Workers Compensation
- Disability Payments

Please only send COPIES of documents, do not send ORIGINAL documents.
Please DO NOT send copies of State or Federal tax returns.

Furnish copy of monthly benefit statement for income sources marked:

☐ Social Security or State Disability
☐ Public Assistance
☐ Company Pension
☐ Veteran Benefits
☐ Interest
☐ Alimony
☐ Child Support
☐ Unemployment
☐ Worker's Compensation
☐ 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:

MRN _____

Signature of Pharmacy Patient Advocate receiving Financial Application: _____

Upstate University Hospital – Outpatient Pharmacy
Pharmacy Patient Advocate
750 E. Adams Street
Syracuse, NY 13210
UpstateMedHelp@upstate.edu
315-464-4221 (Fax)

If you have any questions in regards to completing this application, please contact us: 315-464-9862.