Ellis MEDICINE

Bellevue Woman's Center
Ellis Health Center
Ellis Hospital

Instructions for Financial Assistance Application

I hereby make an application for Ellis Medicine Financial Assistance Program. I understand that I must comply with the following requirements and that failure to comply with any or all of the requirements will result in denial of my Financial Assistance application. Any misrepresentation will result in the denial of this and all future applications.

Those patients who may qualify for a governmental program (Medicaid or other governmental program) will be referred to the appropriate program to complete an application. Ellis Medicine has Financial Advocates that can assist in this process.

I UNDERSTAND THAT I MUST:

1. Provide proof of my entire claimed "**Household Family Income**", include all income from individuals listed in the application as family.

Acceptable Income Verification:

- **Most current month pay stub(s)*Last 4 consecutive**
- **Any official documentation that clearly demonstrates one's financial situation, i.e., pension check, social security check, or unemployment benefits.**
- ***If you are Self- Employed you must include your Schedule C, K or F Profit and Loss form as proof of income.***

Please note that a Picture ID, Copy of insurance card (if applicable) and proof of permanent residency must be included. **(i.e. such as an invoice or utility bill)**

2. Submit all insurance payments made to me by any insurance company as a result of the incurrence of the bills for which I am making this application. I understand that the percentage discount I receive will be on any unpaid balances after all other sources of payment have been applied.

Financial Assistance covers the patient financial obligation after ALL insurance(s) or self-pay payments/adjustments have been applied.

Applicants Signature: _____

Date: _____

PLEASE RETURN BY_____

***Application must be returned with the required documentation within 30 day of the date of this application.*

(Office Use Only)

Received by: _____

Date submitted to billing office: _____

Date received by PFS: _____

ELLIS MEDICINE FINANCIAL ASSISTANCE APPLICATION

APPLICANT/PATIENT INFORMATION

Name:		
Date of birth:	***SSN:***	***Phone:***
Current address:		
City:	***State:***	***Zip Code:***
Insurance Co Name:	**Policy ID#**	**Group#**
Dental Co. Name	**Policy Holder Name:**	***Group#***

PATIENT(S) WHO ARE APPLYING (SPOUSE & CHILDREN CAN BE INCLUDED)
RESPONSIBLE PARTY: _____

(THE PERSON RESPONSIBLE FOR THE PAYMENT OF THIS BILL)

Spouse Information

Name:		
Date of birth:	***SSN:***	***Phone:***
Current address:		
City:	***State:***	***Zip Code:***
Insurance Co. Name:	**Policy ID:**	**Group#**
Dental Co. Name	**Policy Holder Name:**	**Group#**

Child/Dependent Information

Name:		
Date of birth:	***SSN:***	***Phone:***
Current address:		
City:	***State:***	***Zip Code:***
Insurance Co. Name:	**Policy ID:**	**Group#**
Dental Co. Name	**Policy Holder Name:**	**Group#**

Child/Dependent Information

Name:		
Date of birth:	**SSN:**	**Phone:**
Current address:		
City:	**State:**	**Zip Code:**
Insurance Co. Name:	**Policy ID:**	**Group#**
Dental Co. Name	**Policy Holder Name:**	**Group#**

HOUSEHOLD FAMILY INCOME

All items listed refer to the entire family unit

Attach supporting documentation for all income entered

	Patient	Spouse	Other household Member	Other household Member
☐ Income (Salary)				
☐ Social Security/Pension				
☐ Public Assistance				
☐ Workers Compensation				
☐ Child Support				
☐ Alimony				
☐ Military Family Allotments				
☐ Unemployment Benefits				
☐ Other Sources of Income				
Gross Monthly Income	$	$	$	$

I certify that all items listed in this application are true and correct.

_____ _____

Applicants Signature Date

If the documentation used to prove eligibility is found to be fraudulent, then any approved financial assistance will be revoked and all normal collection efforts will be pursued.

The Financial Assistance Program does not honor any applications for bariatric and cosmetic procedures or select dental services (which include but are not limited to dentures, denture relines, denture adjustments after six months from delivery date, crowns, abutments, implants, root canals, post and cores, cosmetic procedures and occlusal guards/night guards). This program also does not cover services that are not medically necessary, and/or admission(s) to our Skilled Nursing Facility. We also do not cover Schenectady Anesthesia, Schenectady Radiology nor Ambulance Service; please also understand that fees associated with no-shows will not be adjusted if financial assistance is approved.

Please complete the attached application and mail to:

Ellis Medicine -PFS - Mail code 1935
1101 Nott Street
Schenectady, New York 12308

Questions please call: 518.243.1553 or 518.243-1539

Note: The application must be returned with the required documentation within 30 days of the date of this application.