Ellis MEDICINE
Bellevue Woman's Center
Ellis Health Center
Ellis Hospital

1101 Nott Street
Schenectady, NY 12308
518.243.4000
ellismedicine.org

Dear Applicant:

Thank you for your interest in Ellis' Financial Assistance Program. Approval in this program is based on **Household Income.** A household is described as people who live together under the same roof. To qualify for this program, you will need to provide the following for every person living in the household. Enclosed is your application. If all information is not provided, your application will be pended. Once the pending period is over, your application will be cancelled.

To avoid missing information, please **use this checklist** to make sure you have provided all the information for **each person living in the household** before mailing:

Check List – ALL APPLICANTS MUST BE LEGAL RESIDENTS OF NYS

Note: Ellis Medicine has 30 days to process an application after it's received. Please follow-up accordingly. Thank you.

Use X in the box below	What is Needed	Examples of Documents
	Proof of Income	Most current paycheck stubs (4); any official document that indicates one's financial situation (Social Security, pension check, or unemployment benefits) If Self-Employed, provide your Schedule C, K, or F Profit and Loss form as proof of income
	Proof of Insurance	If you have **Health and/or Dental** insurance, please provide a copy of the cards
	Proof of Residency	This proof can be a utility bill or an official invoice
	Picture Identification	Driver's License or Identification Card

Please complete the enclosed application and mail ALL DOCUMENTATION to:
Ellis Medicine
Patient Financial Services (FAA)
1101 Nott Street (Mail Code 1935)
Schenectady, New York 12308
OR
Fax: 518.243.1584 / Email: businessoffice@ellismedicine.org

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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. If you have Health Insurance, the cards must be supplied for billing purposes.

Those patients who may qualify for a governmental program (Medicaid or other governmental programs) 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. Be a Legal resident of NYS
2. Provide proof of my entire claimed "**Household Income**", (This includes all income from all individuals living at/in the same residence), as well as those listed in the application as family. Income documentation is needed to adjudicate the processing of this application; if not received, it will delay the process by 30 days. If still not received, we will have to cancel/deny your request.

Acceptable Income Verification:

- Most current month pay stub(s)*Last 4 consecutive preferred
- Current Federal Income Tax forms
- 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 copies of picture ID, insurance card (if applicable) and proof of permanent residency (i.e. Such as an official invoice or utility bill) must be included. Social Security number must be provided for all adults applying for the Financial Assistance Program.

3. I also understand that if I have Health Insurance, it must be supplied to Ellis for billing purposes. I will 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 payment sources have been applied.
4. Anyone living with parents (and can be claimed on their taxes as a dependent); Financial Assistance eligibility will be determined by including parent's income.

Financial Assistance covers the patient financial obligation after ALL insurance(s) or self-pay payments/adjustments have been applied. **All approved applications for Financial Assistance will be effective for 12 months.**

Please note: Upon submission of a completed Financial Assistance Application to determine eligibility, you may disregard any bills/statements until Ellis Medicine has rendered a decision on your application.

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Applicants Signature: _____ Date: _____

PLEASE RETURN BY: _____

(Office Use Only)

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

Received by: _____

Date submitted to billing office: _____**Date received by PFS:** _____

ELLIS MEDICINE FINANCIAL ASSISTANCE APPLICATION (2020-2021)

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)

Household 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 Members 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 Members 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

Is the combined gross income of **all the members of a household 18 years of age or older**, individuals do not have to be related to be considered members of the same household.

Attach supporting documentation for all income entered

	Patient	Other Household Member	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 applications for All cosmetic procedures some bariatric and 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 do not cover Schenectady Anesthesia, Schenectady Radiology, or 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)
1101 Nott Street (Mail Code 1935)
Schenectady, New York 12308
Fax: 518.243.1584 / Email: businessoffice@ellismedicine.org

If any questions, please contact Customer Service at 518-831-8123

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