Kaleida Health

Financial Assistance Services
Patient Financial Services
726 Exchange Street, 3rd Floor
Buffalo, NY 14210
Office: 716.859.8979 Fax: (716) 859.8657

APPLICANT FOR FINANCIAL ASSISTANCE DISCOUNT
Household Information

Complete information below for applicant(s): All sections need to be completed in full (use NA for not applicable).

LAST NAME	FIRST NAME	DATE OF BIRTH	EMPLOYED/INCOME (Y) OR (N)

Complete information below for all other(s) living in the household:

LAST NAME	FIRST NAME	DATE OF BIRTH	
Address:			
Home Phone:	Cellular Phone:		

BANK/CREDIT UNION ACCOUNTS

List all bank accounts Attach copies of bank statement(s) for the current and previous months (all pages for all open accounts).

BANK/CREDIT UNION ACCOUNTS:
Checking Acct#: _____
Bank Name: _____
Balance: _____

Savings Acct#: _____
Bank Name: _____
Balance: _____

Note: Please submit copies of bank statements with this application. The applicants name and address must be listed on the bank statements.

PROOF HOUSEHOLD YEARLY INCOME.
Income is calculated on an annual basis

- Earned Wages: _____
- Social Security: _____
- Disability: _____
- Unemployment: _____
- Child Support: _____
- Pension: _____
- Alimony: _____
- Dividends, Interest: _____
- Rental Income: _____
- Other Income: _____

Note: Self-Employment: Please submit 3 Month Ledger (Ledger enclosed). Signed dated and notarized

1). Do you currently have any insurance? If so, what insurance plan? Also, please provide a copy of the front and back of the insurance card and enclose with your application _____

2). If you do not have insurance have you spoken to a Facilitated Enroller (Yes or No)? _____

3). If you currently do not have insurance have you applied with the New York State Health Marketplace for Medicaid, Child Health Plus, a Qualified Health Plan (QHP) and/or any other insurance plans on your own? ____ If yes, please provide a copy with the date you applied and the determination, approval or denial.

Please call the Financial Assistance Office at 716-859-8979 to make an appointment to meet with a representative.
1/2018

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I certify that the information provided in this application is true and accurate to the best of my knowledge.

I understand that this application is made so that the hospital can assess my eligibility under the Kaleida Health Financial Assistance Policy. If any information I have given is untrue, I understand that the hospital may re-evaluate my financial status and take whatever action deemed appropriate.

I agree to provide additional information as requested in order to determine eligibility. I agree to inform Kaleida Health of any changes in my needs, insurance eligibility, living arrangements and address changes as they occur.

Please be advised that you have 240 days from the date of service to submit a charity care application. If your application is not completed in full it will be denied.

Signed: _____ Date: _____

Signed: _____ Date: _____

Pt Representative: _____ Relationship: _____

Date: _____

For Office Use Only:

△ Checked Eligibility: Patient has no active insurance for outstanding accounts/DOS

△ All required sections of the application are complete

△ All required documentation is submitted

Outstanding items: _____

△ Follow-up letter mailed to applicant. Date mailed: _____

△ Follow-up documents returned to Kaleida Health: Date received: _____

△ Approved: Date: _____

△ Denied: _____ Reason: _____

Patient Financial Svc. Rep Signature: _____

A copy of this document must be kept in the applicants file

Please call the Financial Assistance Office at 716-859-8979 to make an appointment to meet with a representative.

1/2018