ONEIDA HEALTHCARE
321 GENESEE ST, ONEIDA, NEW YORK 13421
FINANCIAL ASSISTANCE PROGRAM APPLICATION

**YOU MUST APPLY FOR FINANCIAL ASSISTANCE WITHIN 120 DAYS FROM THE DATE OF DISCHARGE. THIS COMPLETED FORM ALONG WITH ALL REQUESTED DOCUMENTS MUST BE RETURNED TO THE BUSINESS OFFICE WITHIN 30 DAYS TO BE CONSIDERED. THIS APPLICATION WILL COVER A 6 MONTH PROSPECTIVE PERIOD.**

Name: Last_____ First _____ Middle Initial _____

Address: _____ City/State _____ Zip Code _____

Patients Date of Birth: _____/_____/_____ Social Security # _____-_____-_____

Home Phone _____-_____-_____ Employer _____

Verification of income: **MANDATORY** ( ) **Most Recent Tax Returns** ( ) 2 Month Period Pay Stubs ( )

Benefit Statements ( ) Other (specify) _____ Medicaid Denial (if applicable) _____

**If proof of income is not returned with this application, financial assistance will be delayed or denied.**

Number of persons in household _____

Patient/Guarantor Gross Income $_____

Spouses Gross Income (if applicable) $_____

Social Security payments not included in gross income $_____

Pensions and Annuities not included in gross income $_____

Other income: (please specify) Ex: alimony, child support, etc. $_____

**Total Gross Family Income** $_____

(If your income falls below the Federal Poverty Guidelines you may be asked to apply for Medicaid)

| Date of Service | Patients Name | Account # | Balance |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

I certify that the above information is true and accurate to the best of my knowledge. Further I will make application for any assistance or third party payment (Medicare, Medicaid, Insurance, etc.) which may be available to me for payment of the hospital charges. I will take any action reasonably necessary to obtain such assistance and will assign or pay over to the hospital the amount recovered against the charges, which are subject of this application, regardless of when such payment is received. I understand that this application is made for the purposes of establishing eligibility for services under Oneida Healthcare Center's Financial Assistance Program. If any information I have provided in connection with this application is later determined to be incorrect, eligibility for the Financial Assistance Program will be re-evaluated based on the correct information and I may be responsible for payment of any services previously considered eligible.

Relationship to Patient(s) _____ Signature _____Date ___/___/_____

Our Business Office is open Mon-Fri 9am-3pm. If you have questions regarding this application please call 315-361-2048. Thank You

# FINANCIAL ASSISTANCE PROGRAM WORKSHEET

**THIS SIDE TO BE COMPLETED BY ONEIDA HEALTHCARE BUSINESS OFFICE**

Patients Name:_____

Date application received: _____/_____/_____

Original account balances: $_____ Adjusted account balances: $_____

Approved: _____ Denied: _____ Reason for denial_____

| **Acct#** | **Acct#** | **Acct#** | **Acct#** |
|---|---|---|---|
| **Service** | **Service** | **Service** | **Service** |
| **Balance** | **Balance** | **Balance** | **Balance** |
| **Surchg-** | **Surchg-** | **Surchg-** | **Surchg-** |
| **Sub Total** | **Sub Total** | **Sub Total** | **Sub Total** |
| **%w/o** | **%w/o** | **%w/o** | **%w/o** |
| **SurChg+** | **SurChg+** | **SurChg+** | **SurChg+** |
| **New Bal** | **New Bal** | **New Bal** | **New Bal** |
| | | | |
| **Acct#** | **Acct#** | **Acct#** | **Acct#** |
| **Service** | **Service** | **Service** | **Service** |
| **Balance** | **Balance** | **Balance** | **Balance** |
| **Surchg-** | **Surchg-** | **Surchg-** | **Surchg-** |
| **Sub Total** | **Sub Total** | **Sub Total** | **Sub Total** |
| **%w/o** | **%w/o** | **%w/o** | **%w/o** |
| **SurChg+** | **SurChg+** | **SurChg+** | **SurChg+** |
| **New Bal** | **New Bal** | **New Bal** | **New Bal** |

Date Applicant Notified _____/_____/_____ Notified by: call _____ letter _____ other _____

| **Notes** |
|---|
| |
| |
| |
| |
| |

Hospital Rep: _____ Date: _____/_____/_____

Approved by: _____ Date: _____/_____/_____